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A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities

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The Honourable Claude Richmond
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
V8V 1X4

Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2003/2004 Report 1: A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities.

Wayne Strelioff

Wayne Strelioff, CA
Auditor General

Victoria, British Columbia
May 2003

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

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Auditor General's Comments

Wayne Strelioff, CA
Auditor General

Performance agreements are becoming common in the public sector around the world. Their purpose is to enhance accountability by setting out agreed upon performance expectations, requiring reports on how expectations are met, and providing incentives. In July 2002, the Ministry of Health Services and the six health authorities in British Columbia signed performance agreements for 2002/03 to 2004/05. This is the first time performance agreements have been used to manage the accountability relationship between the ministry and the health authorities.

Putting these agreements in place is a significant step towards strengthening the performance of the British Columbia health care system. We support the concept of increasing accountability through performance agreements and believe they can become an important means of building public confidence. This Office has expressed concern about the lack of accountability in the health care system in the past. In March 2002, for example, we released our report, *Information Use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System*, which concluded that the ministry was allocating resources across the health care system without the benefit of essential cost and performance information. We have continued to look at accountability issues because a strong system of accountability can help ensure that the regional health care system is focused on delivering effective and efficient health services to the public.

We had three main reasons for reviewing the health authority agreements. With the restructuring of the province's regional health care system, we recognized that the agreements needed to succeed as drivers of change and improvement. We also thought it was timely to review these agreements because they are emerging as an accountability tool across government. Finally, we wanted to give the Legislative Assembly and the public greater insight into the value of these types of agreements. We discussed the idea of reviewing the new agreements with the ministry, and it was mutually agreed that this was an opportune time to do so.

We looked at these agreements from the following perspectives: governance, accountability, and performance measurement and reporting. While we believe that the agreements represent an important development, overall we concluded that they need to evolve considerably before they can be regarded as effective tools.

Many improvements are needed to provide greater focus and clarity about who is accountable to whom, how accountability is to be achieved and selecting the right performance measures.

In our view, performance agreements should become the key accountability documents between the ministry and health authorities. This report summarizes the outstanding features of the agreements, offers observations on their strengths and weaknesses, and puts forward suggestions for future direction.

Bringing clarity to a structure as complex as the regional health system is a very difficult challenge. We found that publicly funded health care systems worldwide are struggling with many of the issues raised in this report and that no "gold standard" for performance agreements yet exists. And while our findings should be read in this context, we believe the agreements have the potential to become a critical factor in strengthening the management and accountability of the regional health care system.

Governance: Who is accountable for the performance agreements?

Our first major finding is that the agreements lack a specific purpose. As a result, the ministry and health authorities do not hold a common view of what the agreements are trying to achieve, which has put the agreements at risk of becoming too many things to too many people. We believe the ministry and health authorities need to refocus the agreements as organizational accountability documents, and include clear descriptions of:

- responsibilities;
- objectives;
- performance measures;
- reporting requirements; and
- incentives and consequences.

To address the question of who is accountable for the agreements, we looked at the governance structure for the regional health care system. We found that the Minister of Health Services is ultimately accountable for the performance of the system, while the health authority board is accountable to the Minister for the performance of the health authority. Each agreement, however, is signed by four parties: the Minister, the Deputy Minister, the Chair

(on behalf of the health authority board), and the CEO of the health authority. This contributes to multiple accountabilities within the agreements and overly complex relationships among the four individuals.

In addition, to hold a health authority accountable for meeting a specified level of performance, we believe that greater clarity is needed about who makes decisions, when decisions are to be jointly made, and how unusually sensitive or controversial issues should be handled.

Accountability: How can accountability be improved through the performance agreements?

We found that the agreements have not achieved their potential of becoming the key accountability documents between the ministry and each health authority. One main reason for this finding is that the agreements do not state the most important objectives for the regional health care system. Each agreement has a list of "givens" which summarize broad objectives for the health care system, reference other accountability documents and outline a number of general operational requirements. In our opinion, this list of "givens" is not focused enough. The agreements need to identify clear, prioritized and balanced objectives that can be used to guide the regional health care system.

To improve accountability through the performance agreements, planning and organizational capacity in the ministry and health authorities must be better aligned to support meeting the expectations set out in the agreements. The ministry and the health authorities recognize that their capacity to prepare, analyze and deliver on the requirements of the performance agreements need continued development.

We also found that the process used for establishing the performance agreements had been rushed, not allowing enough time for full collaboration between the ministry and health authorities. Setting up the agreements was one of many major initiatives underway in implementing the new regional health authority structure, including the redesign of services to be provided through the health authorities. In future, a more collaborative process, based on a relationship of mutual trust and respect is needed so that the agreements are fair and realistic.

Performance Measurement and Reporting: What are the right performance measures to include in the agreements?

The performance agreements contain an eclectic gathering of measures and issues, varying in clarity and usefulness. To improve this, we concluded that the measures should be:

- closely linked to objectives for the health care system, to ensure that only the most important areas of performance are measured;
- connected with decision-making needs, so that the ministry and the health authorities will be able to make decisions based on relevant information; and
- selected to form a balanced set of measures that address all important dimensions of performance.

In selecting performance measures for the agreements, the ministry focused on areas for immediate improvement. While we think this is a valid approach, we believe that enduring, long-term measures of success for the health care system (e.g., patient outcomes) should also be captured in the agreements.

Good performance agreements set measurable targets. We found that many of the targets in the agreements are vague, e.g., improvement in the performance of emergency health services. Apart from the financial targets, they are often not seen by the health authorities as requiring significant effort. Since these are the first set of targets, it is understandable that further experience is needed for realistic target-setting. As targets develop, we strongly believe that a continuous learning approach be taken to evaluating their achievement. We suggest that performance results be used initially as a point of inquiry, rather than to make "pass/fail" judgments based on meeting the targets.

As well, we found that incentives and consequences in the performance agreements to be insufficient. There is only one incentive and it focuses on the CEO of each health authority, even though these performance agreements are between organizations. We therefore suggest that a variety of organizational incentives and consequences (e.g., recognition and increased responsibility) be considered and built into the new agreements to be applied on a graduated basis from minor to major.

Reporting requirements are also not specified in the existing agreements. Decisions about reporting drive both the flow of information (what will be reported to whom and when) and the cost of preparing and transmitting that information. In general, we believe that reporting should be frequent enough to support timely decision-making, but not so frequent as to overwhelm users.

Finally, we found that the agreements do not provide for independent evaluations of health authority performance, nor auditing of the information they provide. Experience in other jurisdictions suggests that there is a need for independent evaluation and audit, especially when incentives and consequences are involved.

Looking Forward

The ministry and health authorities have taken a major step forward in implementing this first set of agreements. We believe there is a real commitment to improving the agreements, as greater experience is gained over time. In this report, we offer 20 recommendations on future directions for the agreements (summarized in Appendix D). Some are broad and will require significant analysis and effort to pursue. In making these recommendations, we acknowledge the complexity of the task, as well as the importance of making these agreements as effective as possible.

Our main recommendations are as follows:

- **The purpose of the agreements should be clearly defined and the agreements should be designed around that purpose. We suggest that the design be based on an organizational performance agreement model that clearly outlines who is to be held accountable for the performance expectations within the regional health care system.**
- **The agreements need to include clear objectives distilled from a variety of major direction-setting and operational documents.**
- **A more collaborative approach to drafting the agreement is needed, with a timeline that allows for greater participation by the health authorities. The agreements should be brought into the ministry's and health authorities' ongoing management and decision-making processes, and not rushed through a once-a-year initiative.**

- **Performance measures in the agreements should be confined to those critical for decision-making, and tightly linked to objectives and improvement priorities. A balanced set of measures is essential to ensure that decision-making is based on all the key dimensions of performance.**
- **Reporting requirements should be based on decision-making needs, to avoid overload.**

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I wish to thank the key people involved in this review—those who drafted the agreements and those who are working to fulfill the terms of the agreements. My staff found a real commitment to improvement as they met with individuals in the health authorities and in the ministry. I believe that such commitment is vital to overcoming any shortcomings in the current performance agreements, and I wish the ministry and the authorities success in their efforts.

Wayne Strelioff

Wayne K. Strelioff, CA
Auditor General

Victoria British Columbia
May, 2003

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Detailed Report

Performance agreements: What are they supposed to achieve, and how are they used?

The purpose of this review was to assess the performance agreements signed between the ministry and British Columbia's health authorities in 2002, to determine if the agreements are effective in improving accountability for the delivery of regional health services to the public. An example of a performance agreement is provided in Appendix A.

Each of the six performance agreements are between the ministry and the:

- Northern Health Authority
- Interior Health Authority
- Vancouver Island Health Authority
- Vancouver Coastal Health Authority
- Fraser Health Authority
- Provincial Health Services Authority

We reviewed the clarity, relevance and appropriateness of the agreements, including who is responsible for what, and how they are to be held accountable. In doing so, we recognized that performance management within the health care sector is very complex and that these agreements are new and evolving.

Our review was performed in accordance with assurance standards recommended by the Canadian Institute of Chartered Accountants, and was carried out between May 2002 and March 2003. Through enquiry, discussion and analysis, we examined the processes used to create the performance agreements, the content of the agreements, and the context. We also reviewed developments in other jurisdictions.

These agreements exist within a broad system of governance and strategic management processes for the health sector. We did not conduct a detailed examination of these processes, but we did review them in terms of how they relate to the performance agreements.

Restructuring British Columbia's regional health care system

The provincial government launched the *New Era for Patient-Centred Health Care: Building a Sustainable, Accountable Structure for Delivery of High-Quality Patient Services* initiative in December 2001 to meet its commitment to renew the health care system. The first step involved creating a governance and management structure that streamlined the province's network of 52 health authorities, boards, councils and societies. There are now six health authorities: Northern, Interior, Vancouver Island, Vancouver Coastal, Fraser and a centralized provincial health authority that is focused on highly specialized programs such as cancer treatment, cardiac care and organ transplants.

In the *New Era for Patient-Centered Health Care* document, government stated that it expects this new structure to achieve:

- greater efficiency
- more effective service delivery
- stronger accountability
- better management and leadership

Services delivered through the health authorities involve all the major program areas: acute care, continuing care, tertiary care, adult mental health and public/preventive health programs. They do not include the Medical Services Plan, Pharmacare and ambulance services.

The three-year performance agreements required each health authority to develop annual service redesign plans, and the first of these were released on April 23, 2002. The extent of the changes being implemented garnered significant public attention because of their direct effects on front-line services, such as hospital closures, changes to available medical beds, consolidation of services, and outsourcing or privatization.

Performance agreements are being used in several jurisdictions around the world

Health care systems around the world are changing in two major ways. First, there is an emphasis on continuous quality improvement, bringing with it a focus on outcomes, effectiveness and efficiency. Second, new accountability practices are being introduced, both to meet management's needs and to satisfy the public's increasing demand for information. Together these changes are affecting the organization and delivery of health care, and highlighting the need for tools to improve practice and measure performance.

While many jurisdictions have made attempts in the past to improve performance and to improve accountability of their health care systems, success has been elusive and many are still struggling with basic issues. Such attempts have often lacked a comprehensive understanding of performance, clear lines of authority, and effective incentives. It is now clear that leaders of a health care system must set well-defined expectations and then monitor and respond to actual performance against those expectations. Performance agreements have the potential to be a vehicle for achieving this.

To determine how these agreements can be used in the health sector, we looked at their implementation in various jurisdictions. In Canada, performance agreements are still a relatively new concept. No "gold standard" appears to have been established yet.

- Alberta has been using business plans for several years to hold health authorities accountable. However, the province is now considering the use of performance agreements instead.
- Manitoba is introducing performance agreements.
- Saskatchewan has been using performance agreements since 1997/98, and is currently redesigning them.

Internationally, there is greater experience with performance agreements in the health sector. Many countries are finding them useful, though the form and content of the agreements continue to evolve and be refined (see Appendix B).

- The United Kingdom uses three-year performance plans.

- New Zealand has Crown Funding Agreements.
- In Australia, the state of New South Wales uses performance agreements.
- The United States uses agreements within the Department of Veterans Affairs and the Department of Health and Human Services.

The United States General Accounting Office (GAO) has also reviewed whether these types of agreements can lead to improved performance. In their October 2000 report, *Emerging Benefits from Selected Agencies' Use of Performance Agreements*, the GAO identified five key improvements:

1. strengthened alignment of results-oriented goals with daily operation;
2. fostering of collaboration across organizational boundaries;
3. enhanced opportunities to discuss and routinely use performance information to make program improvements;
4. provision of results-oriented basis for individual accountability; and
5. continuity of program goals maintained during leadership transitions.

Introducing clarity into a structure as complex as the regional health care system is a very difficult challenge for governments. However, we believe that performance agreements can offer an important means of addressing this challenge, if used effectively.

Introducing performance agreements into British Columbia's health sector

Two provincial ministries, the Ministry of Health Planning and the Ministry of Health Services, are responsible to the British Columbia Legislative Assembly for the overall planning and direction of the health care system. A significant part of this responsibility is to hold health authorities accountable for performance.

To this end, the Ministry of Health Services and health authorities signed performance agreements in 2002 that hold health authorities "accountable for the delivery of patient care, health outcomes and how health dollars are spent." The agreements are considered critical components in managing the regional health system's ability to deliver a sustainable, affordable public health system.

The performance agreements are intended to be key documents outlining how governance, accountability and performance will be linked and managed within this complex environment.

We recognize as a significant step forward the ministry's and health authorities' efforts to date in implementing performance agreements. However, as we discuss in this report, much work is still required to ensure these agreements add value, rather than further complexity, to regional health care delivery in British Columbia.

Governance: Who is accountable for the performance agreements?

The performance agreements are a critical new component in the governance structure for the regional health care system. They are intended to address many governance-related issues, including roles and responsibilities, relationships and accountabilities. In effect, they indicate who is in charge, who sets direction, who makes decisions, who monitors progress and, ultimately, who is accountable. Without clarity on these issues within the performance agreements, the agreements have limited potential to improve governance in the system.

In reviewing the agreements, we concluded that they require significant improvement to clarify who is accountable for meeting the expectations set out in them.

The ministry and health authorities have not identified a common purpose for the performance agreements

Performance agreements should have a clear and understandable purpose. Otherwise, the parties involved will not agree on the roles, responsibilities and accountabilities that should be included within the agreements.

We found that the ministry and health authorities generally understand that they are to be held accountable for meeting the requirements set out in the agreements. However, there are different views as to what the agreements are intended to achieve.

Various types of performance agreements are used in public sectors around the world and each has a different purpose (see Exhibit 1).

Exhibit 1

Models of performance-related documents

Service Contracts	Performance agreements designed as service contracts are used to purchase specified services. Each contract sets out the terms and conditions under which a ministry will purchase services from a health authority. There is usually a clear distinction between the purchaser (ministry) and the provider (health authority) of the services. Contractual obligations are established that have repercussions if either party does not abide by the terms and conditions of the contract.
Organizational Performance Agreements	Organizational performance agreements are used to "uncouple" or distinguish between the functions of a ministry and a health authority. They articulate the ministry's expectations, the health authority's objectives, how performance will be reported, and how that data will be used to trigger consequences, positive and negative. This model is discussed in *The Reinventor's Fieldbook: Tools for Transforming Your Government* by David Osborne and Peter Plastrik (Jossey-Bass, 2000).
Personal Performance Agreements	Personal performance agreements are used to tie individual performance of a Chief Executive Officer (CEO) or board member of a health authority to strategic objectives. This type of agreement sets out the specific responsibilities for an individual in his or her organizational role, as part of a personal appointment or performance appraisal system.
Business Plans	Business plans can be used as a type of performance agreement. They describe the health authority's high-level organizational objectives, clarify its mandate, mission, goals and objectives, and outline the strategies and resources it intends to use to achieve its objectives. Performance measures may also be included to indicate progress toward the achievement of objectives.
Issues Management Tracking Documents	Issues management tracking documents are used to monitor whether a health authority is making progress on key priorities. They usually include a list of issues, accompanied by a reporting outline that indicates the status of the issue and when it was last checked.

In our interviews and through analyzing the health authority agreements, we found a very mixed model described that contains a variety of the characteristics in Exhibit 1.

The uncertainty created by this mix was evident in our interviews with the ministry and health authorities. There is no clear, well-understood rationale behind why the agreements have been implemented or what they should include. Different views were expressed on whether individuals or organizations should be held accountable, and whether results-based performance

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or process-related activities should be contained within the agreements. In our opinion, such lack of clarity among the parties to the agreements undermines the value of the documents.

Recommendation

We recommend that the purpose of the performance agreements be clearly defined and that the agreements then be designed around that purpose. In our view, the organizational performance agreement model is the closest fit to what most of the interviewees felt was the primary purpose for these documents. This model also seems to capture the intended level of accountability best—that being the organization.

Roles and responsibilities in the performance agreements are not consistent with governance policy

Performance agreements should be clear on who is accountable and what they are accountable for. The roles and responsibilities should be consistent with the overall governance structure to ensure there are no contradictions about who is in charge, who sets direction, who makes decisions, who monitors progress and who is accountable for what. In our view, the current agreements lack the necessary consistency with the health sector's governance structure.

The governance structure delegates responsibility for delivering the majority of regional health services from the ministry to the health authorities. This governance model was put in place in April 1997. Since then, the ministry has been focusing its role on stewardship and leadership responsibilities. These are summarized in the ministry's service plan and involve:

"communicating, monitoring and securing compliance with government performance expectations (e.g. policy, standards, service volumes, health outcomes quality, budget). Key functions will be the routine monitoring of the health sector's compliance and performance, providing advice and remedial support as required, undertaking comprehensive health authority appraisals, and enforcing consequences if health authorities fall short in delivering the results laid out in their performance contracts."

We found that the ministry and health authorities have made progress in distinguishing between leadership and service delivery roles, but a clear distinction is still being worked out. The agreements currently provide for detailed monitoring by the ministry. For example, much of Schedule B (Appendix A) is a process-oriented list of issues to be tracked. This is not consistent with the monitoring of higher-level performance expectations referenced above.

Recommendation

We recommend that the performance agreements be better structured to clarify the roles and responsibilities for stewardship and service delivery and to focus on higher-level performance expectations.

The decision-making roles of the ministry and health authorities need greater clarity

If an organization does not have decision-making authority consistent with its performance expectations, then it is not reasonable to hold that organization accountable for meeting those expectations. We found that one of the main areas of difficulty in sorting out roles and responsibilities for the performance agreements stems from uncertainty over decision-making authority. There is ambiguity as to who—the Minister, Deputy Minister, health authority board, or CEOs—can make what decisions.

Decision-making authority is regularly put to the test in virtually every jurisdiction's regionalized health care system. This is particularly the case when decisions taken or contemplated generate a high level of public interest or controversy. When a health authority has made a controversial decision, it is not uncommon for a ministry to step in to assume control. A common scenario is outlined in the example of when a health authority decides to close a hospital (see sidebar).

The Health Authority That Closed a Hospital

The health sector has multiple goals and objectives, and sometimes these are in conflict with each other. The following story illustrates this point. While the events are fictitious, they represent a situation that commonly arises in Canada's health care system.

In February 2002, the board of the Eastern Health Authority met to hear from the CEO about the budget for the upcoming fiscal year. Board members heard that the Ministry of Health expected them to work within the same financial parameters as the previous year. However, recent salary negotiations and inflationary costs were running at 11%, so savings would have to be found to balance the budget.

At the same meeting, the board also heard concerns over quality and safety at the Ridgeview Community Hospital. Located in a small town, the hospital was too small to sustain specialized levels of care, and qualified doctors and other professionals were becoming increasingly hard to attract and retain. Residents around Ridgeview Community Hospital often went to a larger regional hospital, about a 45-minute drive away, for many of their services.

After discussing this and the budget matters, the board instructed the CEO to investigate the costs, risks and benefits of closing the community hospital and converting it to either a primary health centre or a long-term care residence. The CEO was to investigate the likely health and financial outcomes of having a large regional hospital provide the services previously provided by the community hospital.

The CEO conducted an exhaustive analysis and arrived at the following conclusions.

- Closing the community hospital would actually decrease the risk of adverse health outcomes. Staff at the regional hospital were highly qualified, properly supported, and had significant skill levels resulting from frequent repetition of complex procedures.
- Cost savings of $3 million could be achieved by consolidating the community hospital services in the regional hospital.
- Risks around transportation of patients to the regional hospital could be minimized by ensuring an adequate level of ambulance service. Risks of delayed treatment could be minimized by maintaining a small first-response station in the Ridgeview hospital building.

Based on this evidence, the board decided to close the community hospital and announced the decision in a press release. The local media reported the decision extensively.

Almost immediately, the people of Ridgeview organized to fight the closure. They argued that having the hospital in town provided them with a sense of security. They needed to know that they would be treated immediately in an emergency. They objected to taking sick people out of their community, and stressed the difficulties for families who needed to visit their loved ones in a hospital an hour away by car. The Mayor and councillors were concerned about the impact the hospital closure would have on the economic life of the town. The local MLA's phone began to ring. The Minister of Health also began to hear from the community.

The government, which had devolved decision-making authority to the health authority, was looking at a difficult choice. Faced with a well-organized and angry community, it was under pressure to reverse the decision. However, doing so would result in the board being unable to achieve goals set out by the government, and would remove from the board true accountability and authority for making decisions. It would also result in a poorer quality of health care. Still, in a public system, the wishes of the community had to be heard. The Minister ultimately decided to reverse the decision of the board, and compensated it by increasing the authority's budgetary allowance.

This raises questions about the allocation of responsibility to make decisions in a regionalized system. Performance agreements can be used to reduce uncertainty by setting out such arrangements in advance, while recognizing the reality that the political dimension of these decisions may necessitate changing such an arrangement.

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The government, which had devolved decision-making authority to the health authority, was looking at a difficult choice. Faced with a well-organized and angry community, it was under pressure to reverse the decision. However, doing so would result in the board being unable to achieve goals set out by the government, and would remove from the board true accountability and authority for making decisions. It would also result in a poorer quality of health care. Still, in a public system, the wishes of the community had to be heard. The Minister ultimately decided to reverse the decision of the board, and compensated it by increasing the authority's budgetary allowance.

This raises questions about the allocation of responsibility to make decisions in a regionalized system. Performance agreements can be used to reduce uncertainty by setting out such arrangements in advance, while recognizing the reality that the political dimension of these decisions may necessitate changing such an arrangement.

This uncertainty in decision-making authority is evident across Canada. According to a national survey of board members, CEOs and senior managers in health ministries, the majority confirmed that the division of authority between health authorities and ministries is not clear (Exhibit 2). The analysis behind this survey found that clarity does not evolve naturally over time, and the ministry and health authorities will need to make a concerted effort to improve it.

In British Columbia, the closure of long-term care beds is one example of where uncertainty in decision-making authority has created difficulties. The performance agreements specify that a greater proportion of clients with high care needs are to be looked after at home or in non-institutional facilities. This would then enable the closure of more expensive long-term care beds. However, to meet this requirement, ministry policy guidelines were needed, in particular due to the public sensitivity surrounding these bed closures. Development of these guidelines took 4–6 months and affected the decision-making authority of health authorities. Therefore, whether health authorities could be held accountable for transferring the targeted number of high care patients out of long-term care beds during 2002/03 is debatable. In this case, a change to the performance agreements may have been warranted.

Exhibit 2

How clear is provincial-regional division of authority?

	Boards	CEOs	Ministries
	(percent of each group in agreement)		
The division of authority between RHAs and the Ministry of Health is clear	50	31	32

Source: Canadian Centre for Analysis of Regionalization and Health, December, 2002

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Recommendation

We recommend that the ministry and health authorities work to reduce ambiguity over decision-making authority by adopting a decision-making framework that articulates who is accountable for which decisions and how exceptional cases will be handled. We recognize that this will be a complex undertaking due to the inherent difficulties in governing within a publicly funded health care system.

The Minister and the Board are the two parties ultimately accountable for meeting the expectations of the agreements

Performance agreements are generally signed by individuals to create a personal obligation in delivering on expectations set out in the agreements. The current agreements are signed by four parties: the Minister of Health Services, the Deputy Minister of Health Services, the Board Chair (on behalf of the board) and the CEO of the health authority. This was done in part as a practical measure because some of the health authorities did not yet have boards in place when the agreements were being developed. However, we found from discussions with the ministry and review of the provisions in the agreements that the intention is to hold all four signatories accountable.

According to the governance policy set out in the Health Authorities Act and in the ministry's *Guide for Board Chairs and Chief Executive Officers*, the reporting relationships among the four parties to the agreements are as outlined in Exhibit 3.

Unless the performance agreements are consistent with this governance arrangement, accountabilities will be unclear. Since it is the Minister and the Board who are held ultimately accountable for meeting performance agreement expectations, we believe that the only two signatories to the agreements should be the Minister and Board Chair (on behalf of the board).

In reality, we understand the need for strong linkages and communication between the four parties and recognize that some blurring of accountabilities is inevitable. However, we found the governance relationships in the province's health sector to be overly complex, with multiple accountabilities (see Exhibit 4).

Although Board Chairs are appointed by the Minister of Health Services, they are recruited by the Premier's Office through the Board Resourcing and Development Office. Some Board Chairs believe that the involvement of the Premier's Office in their appointment process means that they are also accountable to the Premier. Thus, while on health authority management issues, the Chairs feel they are responsible to the Minister of Health Services, they also see themselves as responsible to the Premier for overall board performance. This is inconsistent with the formal governance policy discussed above. In addition, we found that Board Chairs feel they have many external accountabilities related to the public, patients, local politicians and service providers, and that conflicts could arise in meeting both internal and external accountabilities.

Ambiguity in the accountability of CEOs also exists. Traditionally, boards decide on CEO appointments, terminations and remuneration. Again we found it was unclear whether the CEOs are accountable to the boards, the Minister, or both. This

Exhibit 3

Governance Structure, As Designed

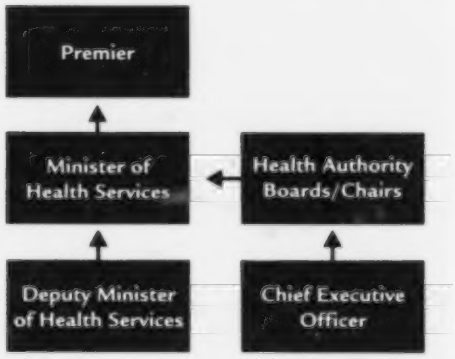
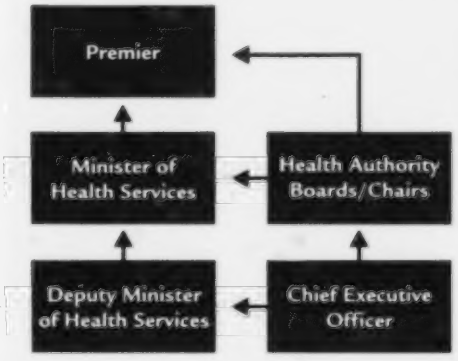


Exhibit 4

Governance Structure, As Implemented



situation creates a number of potential risks. One is that the boards can be bypassed in strategic decision-making, becoming advisory boards rather than governing boards. Another is that the CEO will receive conflicting messages. A third risk is that the CEO will view his or her job as that of managing the board on behalf of the ministry, rather than reporting to the board.

The reality is that the Deputy Minister and CEO have direct roles in the development and implementation of the agreements. Therefore, instead of requiring the Deputy Minister and CEO to sign the agreement, the ministry should consider outlining their general roles in relation to the agreements. It is not uncommon to have separate management agreements between a Minister and a Deputy Minister, and between a board and its CEO that articulate the expectations of these relationships.

Recommendation

We recommend that the performance agreements be signed by the Minister and the Chair of the health authority, on behalf of the board, as they are directly accountable for responsibilities being delegated within the performance agreements. Consideration should also be given to defining the roles of the Deputy Minister and CEOs in separate management agreements.

The ministry and health authorities need to commit to a relationship built on mutual respect and partnership

We found a strong emphasis on control associated with the performance agreements currently in place. For example, the ministry's service plan for 2002/03 to 2004/06 describes one of the ministry's strategic shifts as being to attain "financial control through strong performance contracts between health authorities and the ministry." As discussed earlier, the ministry describes part of its core business as being that of "undertaking annual comprehensive health authority appraisals, and enforcing consequences if health authorities fall short in delivering the results laid out in their performance contracts."

In our view, the relationship between the ministry and health authorities requires a high degree of trust, cooperation and mutual respect—rather than command and control. If a health authority does not meet expectations, the ministry is unable to "contract" with another service provider. There are no ready substitutes.

In other jurisdictions, including the United Kingdom and New Zealand, the relationship between ministries and health authorities has evolved towards greater cooperation and the pursuit of common objectives. The emphasis in performance agreements in these jurisdictions is on improvement and learning. While the central agencies still have the right to apply consequences, they are seen more as a last resort, rather than a primary focus of the agreements. We discuss this further in the "Performance Measurement and Reporting" section of this report.

Currently, British Columbia's health authority agreements contain only one main responsibility for the ministry—namely, to provide funding on a bi-weekly basis. This is obviously an extremely important responsibility, but we think that others built into the agreements would help establish a greater sense of partnership between the parties. For example, the ministry could assume responsibility for providing health authorities with:

- better coordinated and timely strategic and policy direction;
- regular feedback on performance;
- central support to coordinate and manage issues at a province-wide level; and
- support in data collection and the analysis of trends or emerging issues facing the health sector.

Recommendation

We understand that both the ministry and the health authorities want to move towards a greater partnership relationship. As the performance agreements are further developed and implemented, we recommend that they be consistent with this approach and be based on the values of mutual respect and cooperation.

The performance agreements do not provide for a third-party assessment of board performance

Health authority boards in British Columbia are entrusted to oversee the delivery of high- quality, patient centred care, and to manage a budget of over $6 billion in public funds. This creates a significant public interest in ensuring that the boards have the ability to manage their responsibilities well.

Health authority boards were given specific responsibilities in the Health Authorities Act and the Minister's appointment letters to the Board Chairs (dated December 12, 2001). In addition, best practices for corporate governance are outlined in many reports and guidelines. Among the most influential of these reports is *Beyond Compliance: Building a Governance Culture*, prepared by the Joint Committee on Corporate Governance in November 2001. The Joint Committee included the Toronto Stock Exchange, the Canadian Venture Exchange and the Canadian Institute of Chartered Accountants.

An overview of the key legislated, operational and governance best practices for health authority boards are outlined in Exhibit 5.

There is growing public recognition that the performance of an organization is significantly affected by how well its board manages its responsibilities. Therefore, it is very important to determine if a board is undertaking its responsibilities effectively. Regular assessments of these board responsibilities are essential to making this determination. Some health authority boards told us in our review that they intend to carry out self-assessments for either their own development purposes or to gain national accreditation through the Canadian Council of Health Services Accreditation.

While we agree that a self-assessment is a valuable process, we concluded that a board's responsibilities are significant enough to warrant a third-party performance review. We recognize that as a first step, boards may involve a third-party in their self assessment process. However, there is too much at stake in terms of public interest for effective and efficient health services and the amount of public funds managed by boards, not to move towards a fully independent third-party assessment.

Exhibit 5

Health authority board responsibilities

Legislated Responsibilities Health Authorities Act	Operational Responsibilities December 12, 2001 Minister's Letter	Governance Responsibilities *Beyond Compliance: Building a Governance Culture*
▪ Develop and implement a regional health plan that includes health services, facilities, human resource requirements and reports to the minister on its activities ▪ Prepare and submit budgets to the Minister and allocate resources for the delivery of health services ▪ Deliver regional services ▪ Develop and implement regional standards for the delivery of health services in the region ▪ Monitor, evaluate and comply with provincial and regional standards	▪ Participate on the Ministers' Advisory Forum ▪ Ensure the participation of the CEO at Leadership Council—an operational committee composed of health authority CEOs and ministry executive staff ▪ Establish a process for public and stakeholder consultation ▪ Develop effective health authority organizational structures ▪ Develop effective accountability mechanisms ▪ Manage within budget funding allocations ▪ Review current programs and services and make changes that will result in more effective service delivery	▪ Set broad parameters within which the management team operates, in particular, those for strategic planning, risk management and communications policy ▪ Monitor and assess performance ▪ Provide assurance to shareholders and stakeholders about the integrity of the corporation's reported financial performance ▪ Select the right CEO and his or her compensation ▪ Coach the CEO and management team

Source: *Beyond Compliance: Building a Governance Culture*, joint report of the Toronto Stock Exchange, the Canadian Venture Exchange and the Canadian Institute of Chartered Accountants, November 2001

Recommendation

We recommend that health authority boards evolve their board performance evaluation process from self-assessment to include periodic assessment by an independent third party within a reasonable time period.

Note: We did not set out in this review to conduct a full examination of governance in the regional health care system. We looked at broader governance issues in our 1997/1998 report, *A Review of Governance and Accountability in the Regionalization of Health Services.*

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Accountability: How can accountability be improved through the performance agreements?

Accountability is the obligation to account for responsibilities conferred. In British Columbia's regional health care system, the ministry has delegated responsibility for service delivery to the health authorities. In turn, the health authorities have an obligation to the ministry to account for, and therefore report on, how they have fulfilled that responsibility.

The public has expressed concern over health authorities being given responsibility to deliver services, but having very little accountability to ensure that essential health services are delivered effectively. The ministry is using performance agreements as the key documents to build stronger accountability into this delegation of responsibility.

To assess how accountability is being achieved through the performance agreements, we used the Performance Management System, jointly developed by the Office of the Auditor General and the Deputy Ministers Council, to guide our analysis (Exhibit 6).

We assessed the performance agreements using the five components shown in the system:

- clear objectives
- effective strategies
- aligned management systems
- performance measurement and reporting
- real consequences

Overall, we concluded there is a commitment to improving accountability, but clear objectives are needed and management systems and capacity to support accountability must be developed further.

Exhibit 6

British Columbia Public Sector Performance Management System

Source: *Enhancing Accountability for Performance in the British Columbia Public Sector*, joint report of the Office of the Auditor General and the Deputy Ministers' Council, April 1996

The ministry and health authorities are committed to improving accountability within the regional health care system

Effective leadership is a decisive factor in establishing good accountability, so we assessed whether the performance agreements were evidence of a demonstrated commitment to accountability in the province's health care system.

In our interviews with the ministry and health authorities, we found a commitment to improving accountability, tempered with a realization that current practices and systems need improvement. The introduction of the Budget Transparency and Accountability Act is partly responsible for the growing awareness in the provincial public service of the importance of accountability.

Under this Act, ministries are required to produce annual service plans and reports that outline performance targets and results. The Ministry of Health Services is now producing these plans and reports. It therefore needs performance information from the health authorities so it can report on the performance of the system.

The decision to introduce performance agreements in the health sector is significant in that it sends a signal that accountability for performance is expected to be embedded in the management of the sector.

The performance agreements are not widely seen as *the* key accountability documents, having clear objectives

The ministry has stated publicly that the performance agreements are intended to be the key documents for holding health authorities accountable. This is reflected in publications such as *The Picture of Health,* a long-term vision for the system, and in the ministry's service plan.

In our interviews, however, the ministry and health authorities told us that they feel the performance agreements are a key, but not the key accountability document. This perspective is not surprising when one considers how the agreements are laid out. At the beginning of each agreement, there is a list of "givens" that outline a number of expectations including: objectives for the

whole health system, reference to other accountability documents and lastly, a number of broad operational requirements, as follows:

"Given that:

- The government is committed to providing high quality patient-centred care, improved health and wellness for British Columbians and a sustainable, affordable public health system;
- The government is committed to substantial restructuring of the health care system, while maintaining the priority of patient needs;
- The government expects the health authority to continue to meet the requirements of the various legislation, regulation and policy, remaining in force at April 1, 2002, subject to amendments made from time to time by the Government of British Columbia;
- The government has established directions in A New Era for British Columbia and the Ministry of Health Services Service Plan;
- The government has provided guidance to the health authority through the letter of expectation to the Chair of the Board from the Minister of Health Services, dated December 12, 2001;
- The government will monitor programs, services, and performance indicators to ensure compliance with the above direction and guidance;
- The health authority will continue to provide a broad range of health care and health protection services such as those provided by its predecessor health authorities;
- The health authority will continue to provide comprehensive, accurate, and timely reporting (financial, statistical, program-related, and person-based), as required by the Ministries of Health."

While the list of "givens" does gather a number of important elements together in one place, it does not provide the focus and clarity needed to guide decision-making and operations in the health authorities. We believe that this approach has the effect of burdening the performance agreements with a long list of vague and open-ended compliance items for each health authority. Health authorities expressed a similar concern, saying that the

agreements were laden with too many expectations and that they actually need to look to other sources of information for their key priorities and objectives. While we recognize that many of these expectations are part of the management structure for the system e.g. compliance with legislation, they do not need to form a part of the performance agreements. Too many expectations dilute the importance of the agreements and could eventually lead to them becoming a layer of complexity within the governance arrangements.

We note that over the course of our review, the ministry was working to reduce the number of expectations and develop a set of specific objectives for the regional health care system.

Recommendation

We recommend that the "givens" be distilled and clarified into a set of clear objectives for the regional health care system that are prioritized and balanced. In our view, this is the single biggest improvement that can be made to enable the agreements to become *the* key accountability documents for health authorities.

Greater alignment is needed between the performance agreements and planning for the health care system (effective strategies)

Historically, delivery of health services in Canada has often been driven by issues management and immediate crises. The result is short-term actions that address current challenges, rather than longer-term strategies to address systemic issues within health care.

With a three-year timeframe, the performance agreements help to shift the focus away from dealing with issues of the day, to addressing a multi-year outlook. We believe that this will provide a greater ability for health authorities to focus on outcomes and strategic management practices within the health care system.

We also found that the agreements reference the ministry service plan and the health authority redesign plans. This provides an apparent connection between the agreements and the corporate planning processes of the ministry and health authorities. In practice, these functions are often led by different work units within the ministry and health authorities. Efforts are being made

to coordinate performance management and corporate planning, but the ministry and health authorities recognize that this can be improved. As better coordination evolves internally, operational linkages between the agreements and corporate planning should come as a result.

The ministry has begun the task of developing a long-term comprehensive planning framework for the system, based on the *Picture of Health* document. We noted that the ministry, in its early drafts of the framework, did not refer to the performance agreements in it. This implies that the performance agreements are not yet seen as a central connection between the ministry and health authorities in the long term. In our view, a strong connection is needed to ensure the health authority performance agreements are linked into the longer term comprehensive planning process for the health care system.

Recommendation

We recommend that the ministry and health authorities:

- **continue to strengthen the linkages between the agreements and current planning processes through better coordination; and**
- **include the agreements in the ministry's comprehensive planning framework, so that they are part of the long-term plans for the health care system.**

Ministry and health authority operations and capacity (management systems) require better alignment to respond to the performance agreements

The ministry and health authorities are working to better align their management systems and capacity with the performance agreements. For example, the performance agreements obligate the ministry to provide health authorities with three-year funding estimates by February 22, before the start of the next fiscal year. This is a significant improvement from previous years when budgets were not provided until well into each fiscal year.

Other key management system improvements are needed. Both the ministry and health authorities have recognized they

need to strengthen their organizational capacity to support the performance agreements. The lack of adequate skills and information systems to measure and report has been identified as a high risk in both the ministry and the health authorities.

Within the ministry, the new Performance Management and Improvement Division is taking a lead role in developing capacity. It is the architect of the agreements and has responsibility for monitoring performance. The ministry's capacity to design, analyze and react appropriately to the issues related to the performance agreements will be critical to effective accountability and to the ministry's role as a steward of the system. However, the ministry has indicated to us that attracting additional high-level skills is difficult. It has to operate within the government's job classification system and, in the opinion of ministry management, that system does not adequately support the future requirements of the ministry. As a result, key jobs may be under-classified and underpaid, making it hard for the ministry to recruit and retain appropriate staff.

Health authorities have brought performance management resources into their organization to better respond to the requirements set out in the performance agreements. However, some authorities have told us that there is a shortage of the right skill mix needed to adequately support the agreements, making recruitment difficult.

Accountability requires adequate information systems. Ideally, these systems should be robust enough to operate at different levels of an organization, such as board, senior management and program management. Both the ministry and health authorities expressed concern about the ability of their systems to deliver the kind of information required for effectively monitoring the achievement of strategic objectives.

The ministry has been working on a new performance reporting system that would better monitor system-wide performance. This has not developed beyond the design stage as appropriate baseline data is needed. In the meantime, the ministry is relying on its current systems to provide the performance information it needs.

Accountability: How can accountability be improved through the performance agreements

The health authorities told us that their information systems need significant enhancements to capture the performance information needed e.g. public and population health data. Their first priority is to focus on consolidating systems based on the new health authority structure. In the short term, there would be limited capability to move beyond this consolidation effort to build new performance management systems.

Recommendation

The ministry and health authorities are making several positive changes to link management systems and capacity to the performance agreements. We recommend that continued improvements, especially to support organizational capacity, are needed over time to ensure the system operates in a cohesive, consistent and holistic way.

A better process for negotiating and managing the performance agreements is needed to ensure that they are fair and realistic

The process of drafting and negotiating the existing performance agreements took place in an extremely pressured environment. The ministry required the agreements to be in place very soon after implementing its restructuring process (from 52 entities to the current 6 health authorities). During this time, the new health authorities were fully engaged in developing their redesign plans and putting new boards and management teams in place. As a result, the process was implemented "top-down" rather than as a joint effort between the ministry and health authorities.

The ministry prepared an initial draft of the performance agreements and provided them to the health authorities in March 2002. On behalf of the boards, the newly arrived Board Chairs rejected this initial draft, saying they wanted greater simplicity, clarity and focus. The ministry, on the other hand, said it was seeking some degree of comprehensiveness in what the agreements covered. Negotiations occurred, with the result being a reduction in the number of performance measures and targets and removal of an appendix outlining legislative provisions relevant to the health authorities.

A second draft of the agreements was sent out to the health authorities by the ministry in June 2002. Although the ministry asked for a quick turnaround on approvals, the health authorities would not sign off on the documents without adding one new provision:

"In the event of significant changes in government policy which will seriously reduce the ability of the health authority to achieve the targets set out in this agreement, the parties to this agreement agree to renegotiate its terms to their mutual satisfaction."

This is significant in that it indicates the new boards were able to collectively make a change to the agreements even at this late date. The final performance agreements were made public on the ministry and health authorities websites in July 2002. Despite the rushed process, most of the participants felt that the process was what had to be done to produce the agreements within the given timeframe.

Recommendation

We believe that:

- **a more collaborative approach be used in drafting the performance agreements that allows for greater participation from health authorities;**
- **the evolution of the agreements be more considered and strategic, rather than rushed through a once-a-year process; and**
- **the agreements be made part of the ministry's and health authorities' ongoing management and decision-making processes, with performance-related discussions occurring on a regular basis, and if necessary, mutually agreed upon changes made due to significant, unforeseen circumstances.**

Performance Measurement and Reporting: What are the right performance measures to include in the agreements?

Choosing the right performance measures is critical, not only for performance agreements, but for the effective management of the health care system. However, doing so has proven difficult for health care services around the world. While other jurisdictions have actively developed performance measurement frameworks and systems, consensus on the best frameworks of measures and indicators for health care services still lies in the future.

We analyzed the performance measurement and reporting requirements in British Columbia's current agreements, and concluded that the measures contained in the performance agreements need to be refocused to emphasize results, to ensure balance, and to promote improvement.

We offer several suggestions for improvement. They are general in nature, rather than precise and prescriptive, partly because of a lack of consensus among experts and partly because we believe that a successful framework of measures should be created and owned by the people involved. The task of management should be to establish that ownership while ensuring that leaders, managers and other stakeholders get the reliable information they need to make good decisions and form appropriate judgments. Above all, the measurement framework should be clearly linked to overall objectives for the health care system in British Columbia.

The absence of a clear sense of purpose has led to an eclectic gathering of performance measures and issues being included in the agreements

We found that without a shared sense of purpose, the existing performance agreements do not contain a clear expression of key expectations. Instead, they are a repository of a wide range of issues to be managed, as well as some performance measures.

As noted earlier in this report, the agreements open with a list of "givens." These bind the health authorities to meeting an indeterminate number of performance expectations. For example, one given is that the government expects the health authority to continue "to meet the requirements of the various legislation, regulation and policy, remaining in force at April 1, 2002, subject to amendments from time to time by the Government of British Columbia." In our view, this level of generality precludes effective performance measurement and accountability.

A greater degree of specificity can be found in the two schedules to the agreements. Schedule A, "Priority System Performance Improvements," sets out a series of expectations under the following headings:

- Emergency Health Services
- Surgical and Procedural Services
- Mental Health Services
- Home and Community Care
- Public/Population Health
- Support and Administrative Services

Twenty-two measures or expectations are listed under these headings (the agreement for the Provincial Health Services Authority has an additional four measures). They do not constitute a balanced set of measures of success, nor are they intended to. Instead, they address priorities set by government and the ministry. Of the 22 measures, 15 are concerned with process improvement, two set expectations for internal results, and five address patient/client outcomes.

Schedule B to the agreements, "Outstanding Issues," lists unresolved issues the ministry has identified from reviewing the health authorities' service redesign and budget management plans. Including this schedule in the agreements creates a requirement for the health authority to provide more information to the ministry. As such, it is a tool for tracking issues rather than measuring performance.

While the givens, expectations and priorities of the ministry are legitimate, we question having too many requirements in a performance agreement. In our view, they undermine the focus a performance agreement requires, and reduce the agreement's ability to deliver real accountability.

Recommendation

We recommend that the ministry and the health authorities work to bring focus to the performance agreements by emphasizing the measurement of results, and by working to select only those measures essential for decision-making.

Performance measures in the agreements need to address long-term strategic objectives as well as short-term improvement priorities

As discussed elsewhere in this and other reports by the Office, the health sector in British Columbia has not yet produced a long-term strategic context for the measurement of success. The Ministry of Health Planning set out broad goals in the document entitled *The Picture of Health*, and the ministries are now working on long-range plans that will identify a more specific set of goals and objectives. Meanwhile, in the absence of a detailed strategic plan, the Ministry of Health Services has focused on establishing short-term priorities for improving performance. These priorities are intended to continually change as improvements are made.

We agree with the need for a focus on short-term improvement, but we also believe that the ministry and the authorities should also include enduring measures of success for the system, based on longer-term strategic goals and objectives.

Recommendation

We recommend that the performance agreements include long-term measures of success, as well as measures related to short-term improvements.

The agreements lack an underpinning of guiding principles for reporting and a framework of performance measures

Managing a health care system is far more complex than managing a standard business. Businesses typically have one bottom line (financial), direct lines of command, no public interest mandate, and only a few key measures of success related to the bottom line. This is not the case in the health sector. There are many objectives, the players often act as independent agents, the issues are complex, and there is relatively little agreement on how to measure success.

Choosing measures will not be easy, as the experience of other jurisdictions shows. Nationally, work on creating a common set of enduring measures for health care in Canada started with the September 2001 First Ministers' agreement. These efforts were furthered by the February 2003 First Ministers' Accord on Health

Care. However, the measures selected in these agreements are a mix of population health and other kinds of measures. Population health measures are more useful as measures of health care needs than as performance measures, because most determinants of health status, such as education level, poverty and environmental cleanliness, are beyond the control of health care systems. In the arena of health service management, we believe that it would be more useful to focus measurement on issues that can be controlled or influenced significantly.

In health sectors around the world, those in positions of governance and management have been struggling with effective performance measurement. They face a dilemma: if the number of measures reported is reduced, the risk of inadequate management attention to important issues increases. But if the number of measures increases, focus is lost, and it becomes harder to evaluate overall performance.

Uncontrolled growth in the number performance measures can be costly and demoralizing, entangling management and governance in an expensive and oppressive system of measurement. In British Columbia, the new Chairs of the health authorities are united in their demand for a small number of clear measures of success that they can use to hold their management teams, and themselves, accountable. We think this is a reasonable aim, but one that needs to be tempered given the complexity of health care systems.

Developing a useful set of performance measures for health care requires a systematic approach that includes:

1. selecting a guiding set of principles for reporting;
2. creating a framework of types of measures;
3. applying sound methods to choose measures within the selected framework; and
4. using logic models to identify and select measures of outcomes.

1. Selecting a guiding set of principles for reporting

When starting to identify key performance measures, leaders need to set down what characteristics they want measures to have. These are best expressed in a set of guiding principles, which can act as a filter for accepting or rejecting proposed measures.

Traditionally, health sectors have measured consumption of resources and, to a lesser extent, utilization of services. In more recent times, a shift occurred to assessing internal activities, through processes like accreditation. The coming emphasis is on results, especially outcomes. With this evolution, overseas health care systems have greatly increased the number and variety of measures they use. In some jurisdictions, they have ended up with hundreds of measures, causing high workloads, and creating so much "information" that it is difficult to get a picture of the whole.

In British Columbia, the number and variety of information requests flowing from the ministry to the regions has been onerous, and we found a lack of confidence among health authority management that the ministry can use the information effectively. At the heart of the problem is a lack of consensus on what should be measured, and why.

A set of guiding principles- key characteristics-is the first step in selecting good performance measures. Such principles for public sector organizations and programs have started to emerge in recent years in Canada. For example, in 2002 a Steering Committee on Reporting Principles and Assurance was established in British Columbia at the request of the Select Standing Committee on Public Accounts. The committee, staffed jointly by the Office of the Auditor General and senior management from government, has drafted a set of reporting principles. While these principles had not yet received approval at the time of this report, we think they are worthy of use as guidance for designing a reporting framework for the health sector. They are also consistent with reporting principles proposed by the CCAF, a prominent national research and educational foundation dedicated to building knowledge and meaningful accountability and effective governance and audit.

The principles recommended by the Steering Committee are based on three basic premises:

- The principles should support an open and accountable government.
- The principles should provide a framework for a learning organization.
- Users of performance information should have a basis to understand how performance reports are prepared.

From these assumptions, the Steering Committee established eight principles of what performance reporting should do:

1. Explain the public purpose served.
2. Link goals and results.
3. Focus on the few, critical aspects of performance.
4. Relate results to risk and capacity.
5. Link resources, strategies and results.
6. Provide comparative information.
7. Present credible information, fairly interpreted.
8. Disclose the basis for key reporting judgements.

The British Columbia principles are not the only ones that have been developed. In the U.S., guiding principles for health care measurement have been developed by the National Committee for Quality Assurance (Exhibit 7), and in Australia by New South Wales (Exhibit 9).

Recommendation

We recommend that the ministry and the health authorities adopt the eight guiding principles established by the Steering Committee on Reporting Principles and Assurance (adapting them to the province's health care system) to guide the performance measure selection process.

Exhibit 7

Guiding principles for health care performance measures: U.S.A

In the United States, the National Committee for Quality Assurance arrived at the following set of principles to guide the selection of health care measures. According to the committee, selected measures should have the following attributes:

Relevance:	Meaningfulness
	Health importance
	Financial importance
	Cost effectiveness
	Strategic importance
	Controllability
	Variance among systems
	Potential for improvement
Scientific Soundness:	Clinical evidence
	Reproducible
	Valid
	Accurate
	Case mix adjustment/risk adjustment
	Comparability of data sources
Feasibility:	Precise specification
	Reasonable cost
	Confidentiality
	Logistical feasibility
	Auditability

Source: Health Employer Data and Information Set, HEDIS® 2003, Volume 1: *Narrative: What's in It and Why It Matters*. Washington NCQA, 2002. Reprinted with permission.

2. Creating a Framework

After putting a set of guiding principles into place, the next step is to establish a conceptual framework of measures. This step is essential for a number of reasons. Without a framework, selection of performance measures tends to produce a long list of items and issues that vary widely in importance, precision and usefulness. Also, linkages with strategic objectives and priorities are often unclear. (These problem are reflected in the content of the current British Columbia performance agreements. As we discussed earlier, the agreements are an eclectic gathering of issues and measures.)

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Relevance:	Meaningfulness Health importance Financial importance Cost effectiveness Strategic importance Controllability Variance among systems Potential for improvement
Scientific Soundness:	Clinical evidence Reproducible Valid Accurate Case mix adjustment/risk adjustment Comparability of data sources
Feasibility:	Precise specification Reasonable cost Confidentiality Logistical feasibility Auditability

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When key measures are chosen, people assume these are the most important dimensions of their responsibilities and accordingly focus on them. So if one-dimensional or incomplete measures of success are selected, management attention may be diverted from critical areas not addressed by the measures. For example, in British Columbia's health care system and elsewhere, we have seen considerable focus placed on financial results and on utilization because those areas were being monitored and measured. The result is that less attention has been paid to quality of services or even health outcomes for clients. A well-conceived framework helps ensure that all critical aspects of performance are kept in balance.

There are a number of generic frameworks that can be adapted to the health care system in British Columbia. These have been developed in other countries, and have much in common (see Exhibit 8). The recent Canadian Federal/Provincial/Territorial Agreement (September 2002), also provided for the creation of a measurement framework.

The Vancouver Coastal Health Authority has been experimenting with adapting the Balanced Scorecard, and other health authorities have also taken an interest in it. This model, created by R.S. Kaplan and D.P. Norton in the 1990s, is widely recognized across the public and private sectors as a powerful analytical tool and a support to effective strategy-making and results monitoring.

The Balanced Scorecard framework addresses four aspects of performance:

- Financial
- Customer
- Internal business process
- Learning and growth

While the Balanced Scorecard leaves room for adaptation to different enterprises, it may not explicitly address outcomes, a key area of health care performance. To address outcomes, we suggest that logic models be used. They work well within the Balanced Scorecard approach. We discuss this in item 4 .

Exhibit 8

Jurisdictions and organizations with health care

Many jurisdictions and organizations around the world are developing health care performance measures. We reviewed frameworks from the following sources

- Australian Health Care Agreements (see Exhibit 11)
- Australian Productivity Commission
- Canadian Institute for Health Information (CIHI)
- CIHI/University of Toronto/Ontario Hospital Association
- Commission on Medicare (Saskatchewan)
- Committee for Public Management and Research (Ireland)
- First Ministers' Accord on Health Care Renewal (Canada) (see Exhibit 12)
- Health Canada
- Health Services Utilization and Research Commission (HSURC) (Saskatchewan)
- HEDIS ® (U.S.) (see Exhibit 13)
- Macleans Magazine Health Report
- National Health Service (U.K.) (see Exhibit 10)
- New South Wales (see Exhibit 9)
- New Zealand
- Okanagan Similkameen Health Region
- Organization for Economic Co-operation and Development (OECD)
- Premier's Advisory Council on Health (Alberta)
- Saskatchewan Health Department
- Statistics Canada

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- Organization for Economic Co-operation and Development (OECD)
- Premier's Advisory Council on Health (Alberta)
- Saskatchewan Health Department
- Statistics Canada

Recommendation

We recommend that the ministry and the health authorities work together to create a balanced framework of key performance measures based on strategic objectives and priorities and linked to decision-making needs. We suggest that the British Columbia health care system consider using a framework including the following domains of performance to support evidence-based decision making:

- **Service levels and access**
- **Service quality and appropriateness/client outcomes**
- **Client satisfaction**
- **Financial results**
- **Efficiency/productivity**
- **Sustainability/capacity.**

3. Applying sound methods to choose indicators within the selected framework

Deciding on how to choose key performance measures is important. Processes need to be designed to ensure participation, to establish principles and frameworks, and to create ownership of the measures.

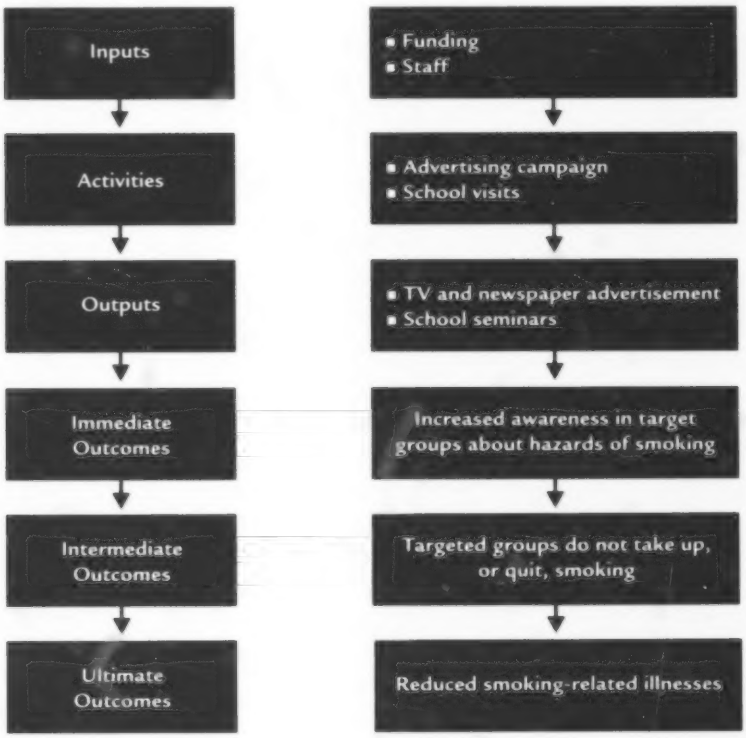
A well-planned process can help overcome major challenges in choosing measures. For example, processes can be designed that address how to resist undue complexity, or how to identify measures that are within the influence of a health authority.

Recommendation

The ministry and the health authorities should agree on a process to select measures in a considered, participative manner.

4. Using logic models to identify key outcomes

In selecting measures of success for a health care system, the most complex area is outcome measurement. Logic models offer an analytical tool for doing this, by graphically representing a program. While they vary in language and style, they commonly share the following design (The example shows a model for a teenage anti-smoking program):



Logic models are in wide use around the world as an important strategic and evaluative tool. They provide a way of looking at the purpose of programs, of examining the appropriateness of programs, and of identifying key measures of success.

A logic model reflects a series of "if/then" statements. If we engage in activity X, then it will result in output Y. If we produce output Y, then it will cause an immediate outcome Z, and so on. The model seeks to explain the "program theory" at a strategic level. This is not to suggest that the relationships are linear, or that they happen neatly in succession over time. In reality, interactions between programs and outcomes are complex. Still, using a logic model does help decision-makers assess program objectives, program theories, and the degree of influence a program has over the results.

For the purposes of outcome measurement, a logic model offers two important insights. First, outcomes exist along a continuum. Second, as one moves along the continuum, the degree of influence diminishes. A health service should be expected to have full control over its inputs, activities and outputs. It should also have a relatively high degree of influence over the immediate outcomes of its services even though these can be affected by outside factors. Intermediate and ultimate health outcomes, however, can be strongly influenced by outside factors beyond the control of health care services.

For example, if a health service program is seeking to reduce teenage smoking, it should be held accountable for the inputs, activities and outputs the program generates (e.g. advertising, seminars, etc). It can also be held accountable for the immediate impact of these efforts (e.g. increased awareness in target groups). The same program, however, may not be able to completely influence higher-level outcomes (e.g. reduced lung cancer), as these cannot easily be attributed to the program. These higher-level outcomes should be measured, but they serve better as measures of health care needs that can be used to guide policy and resource allocation. In a longer-term sense, they can be used as performance measures of the long-term success or failure of policy, or of the overall impact of several programs working with the targeted population.

A logic model can thus be used to set objectives and to determine key performance measures. The intermediate and ultimate intended outcomes can be translated into goals and objectives, and key measures can be derived from these statements.

Recommendation

We recommend that the ministry and the health authorities consider using logic models as part of the process of selecting measures of outcomes for the British Columbia health care system.

Exhibit 9

Performance measurement framework and principles: New South Wales

The State of New South Wales uses four major domains to measure performance:

- Healthier people (selected measures)
- Fairer access
- Quality care (quality improvement, skills, community engagement)
- Better value (efficiency, information systems, asset management)

Principles for selecting measures are that the measures be:

- Relevant
- Objective
- Reflective of the state of development
- Realistic
- Supported by evidence and data
- Within the scope of influence of the authority

Exhibit 10

Performance measurement framework: United Kingdom

The United Kingdom National Health Service (NHS) has identified six domains for performance measures:

- Health improvement
- Fair access
- Effective delivery
- Efficiency
- experience
- Outcomes of care

Growth in the number and types of performance measures and other information requirements prompted the NHS to derive fewer, "smarter" measures and targets that are based more on outcomes and less on process. This is being accompanied by a drive to give greater local autonomy and flexibility.

National targets have been distilled from policy documents and plans into a single framework. Expectations at the local level are to be driven by the national targets.

A process has been established to prevent the proliferation of measures and information requirements coming from the central ministry.

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Exhibit 11

Performance measurement framework: Australia Health Care Agreement (AHCA) indicators

Health care agreements govern the transfer of funding from the Australian national government to states and territories. The agreements provide for monitoring of performance under the following domains:

- Waiting times for access to services
- Indicators of Aboriginal and Torres Strait Islanders health
- Indicators of integration of care processes and indicators of access to primary care
- Measures of quality of care, including patient satisfaction
- Indicators of effort in medical training and medical research
- Mental health reform indicators
- Indicators of access to and quality of palliative care services

Source: Australian National Audit Office, Audit Report No. 21 2002/3

Exhibit 12

Performance measurement framework:
Canada 2003 First Ministers' Accord on Health Care Renewal

The First Ministers' Accord on Health Care Renewal includes the elements of a performance measurement framework for health care systems in Annex A. Those elements are:

- Timely access
- Quality (includes patient satisfaction and outcomes)
- Sustainability (human resources, information systems, value for money)
- Health status and wellness

The annex goes on to specify 40 indicators for ministers "to consider." The Accord includes an agreement that each jurisdiction is to report to its constituents on performance and change.

Exhibit 13

Performance measurement framework: United States Health Employer Data and Information Set (HEDIS®)

This measurement framework is published by the U.S. National Committee for Quality Assurance. The committee asserts that HEDIS is the national standard for health care performance measurement. The measures are organized into eight domains. The committee suggests that no measure be looked at in isolation; rather, measures should be grouped together, based on the needs of the user.

1. Effectiveness of care
2. Access/availability of care
3. Satisfaction with experience of care
4. Health plan stability
5. Use of services
6. Cost of care
7. Informed health care choices
8. Health plan descriptive information

These domains contain 52 measures. Examples include:

Effectiveness of care:

- Childhood immunization status
- Follow-up after hospitalization for mental illness

Access:

- Adult access to preventive/ambulatory health services

Health plan stability:

- Practitioner turnover

Source: Health Employer Data and Information Set HEDIS® 2003, Volume 1: Narrative: What's in It and Why It Matters. Washington NCQA, 2002.
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Targets set in the performance agreements are often vague, and may not be seen as requiring significant effort by the health authorities

Targets are a critical dimension of a successful performance agreement. They need to be clear, unambiguous, measurable and attainable with effort. We found that the targets set in the province's current agreements did not meet these criteria.

Many of the targets in the agreements were statements of expected process improvement, not amenable to precise measurement. For example, a target for 2004/5 is "improvement in the performance of the emergency health services in the health authority, as measured by indicators."

In other cases, targets in the agreements have a high degree of precision. For example, annual targets are set for the "decrease in the alternate level of care days spent by mental health and alcohol and drug clients in hospitals once the primary need for inpatient care has completed." The targets are 0%, 2% and 2% for each of the successive three years covered by the agreement. Another explicit target is to "reduce the annual expenditures for support and administrative services (excluding information systems) by the 2004/5 fiscal year, by at least 7%."

It is not clear to us whether the targets represent a "stretch" for the authorities. Some interviewees commented that the targets had been set in the context of this being the first iteration of the agreements, and that it would have been unwise to set overly ambitious targets until better baseline data and experiences were built up. We think this is a reasonable approach, but expect to see clearer, more challenging targets emerge as experience is gained. Some organizations prefer to set very challenging "stretch targets," often without a solid base of experience. However, we believe this can be counterproductive if individuals see the targets as arbitrary. Given the absence of full baseline and benchmark information in the province's health sector, it will take some time for a consensus to emerge regarding appropriate targets.

Recommendation

We recommend that the ministry and the health authorities work together to establish sound data on current performance, set a philosophy of continuous improvement, ensure all targets are as measurable and clear as possible, and tie incentives to the targets. Ultimately, the ministry and the health authorities should be working to achieve a "gold standard" over a reasonable period. We recognize that this will be a difficult task, and that improvements will only come as experience is gained.

The performance agreements are non-specific about reporting requirements

We found that the existing performance agreements do not specify how performance is to be reported. We believe they need to address reporting, including requirements for frequency, timing and the medium (e.g. web-based technology, paper reports) to be used.

Decisions about reporting are important. They drive the flow of information to decision-makers, and they drive the cost of preparing and transmitting that information. In general, we believe that reporting should be frequent enough to support timely decision making, but not so frequent as to overwhelm users.

The nature of what is being measured should also influence decisions on frequency. For example, high-level population health indicators tend to change slowly, so reporting on a monthly basis would be excessive. At the other extreme, measures of inputs, activities and financial results need to be frequent enough to allow timely decisions to be made in response to the information. In the middle, short-term outcomes and measures of service quality should be reported often enough to meet needs.

Emerging technologies are reshaping the performance reporting task. Many organizations, for instance, are experimenting with a "digital dashboard" approach that captures high-level information, while providing links to underlying detail. Web-based technologies allow the capture of data from remote locations on a timely basis.

Recommendation

We recommend that the performance agreements include reporting provisions that are based on a careful analysis of decision-making needs and use emerging technologies for performance reporting.

There is no provision for auditing or evaluating performance or information

The existing performance agreements do not address how key performance reports can be verified. Given the increasing importance of performance information for decision-making, we believe there is a need to ensure that it is reliable.

In the world of financial reporting, the demand for reliable information led to the creation of an auditing profession. Recent events in the private sector have underscored the importance of having independent audits that provide real assurance. We believe the same considerations apply to the key measures of success being reported under performance agreements. Key decisions will be made and incentives and consequences will be applied based on the information provided. Therefore, the ministry needs periodic assurance that the information coming from regional sources is reliable and fairly presented. Similarly, boards of the health authorities should be receiving assurance from their internal audit departments.

A traditional role of audit is to provide independent assurance about reported information, usually financial statements. More diverse types of information have lately become subject to audit. For example, in 2002, when the federal, provincial and territorial governments of Canada reported on their health indicators, the Auditors General reported on the reliability of the data.

We found that, according to other jurisdictions' experience with performance reporting, two types of assurance are needed. The first is assurance about the relevance and reliability of reported measures. Similar to financial statement auditing, this involves auditors expressing an opinion as to the fairness of presentation and accuracy of the information provided by management.

The second type of assurance is about the underlying processes-why the results are happening as they are. Broad scope evaluations are needed in this case, to supplement reporting by indicators. Indicators have their uses, but ultimately they do not address the root causes of observed performance. They may also miss important dimensions of performance because of the need to simplify and contain the number and variety of measures. We believe indicators should be treated as the starting point of inquiry rather than as a final description of performance. In-depth evaluations can look behind the indicators to gain a deeper understanding of results.

In the United Kingdom, recent developments have led to the creation of an independent body to provide assurance reports and analysis of performance. In April 2002, the UK government announced the creation of a new Commission for Healthcare Audit and Inspection (CHAI). This body consolidates the role of predecessor organizations. The new body's mandate includes validating published performance information. Reports by other audit agencies (e.g. the National Audit Office) have provided valuable information to legislators about the reliability of performance reports by local health authority management, as well as direct assessments of performance of the system.

In the United States, the HEDIS® measures (see Exhibit 13) reported by health care providers are also subject to an independent audit. The National Committee for Quality Assurance certifies auditors, and each health care organization uses these auditors to lead teams that compare the organization's reporting practices with published standards. The audits address areas for improvement and indicate which measures are reportable or not, depending on accuracy.

Recommendation

We recommend that the ministry and the health authorities establish a joint program of independent audits and evaluations for the health sector in British Columbia.

Incentives and consequences written into the performance agreements are insufficient

Accountability is greatly enhanced when incentives and consequences are clearly tied to performance. The current set of performance agreements provide only one incentive, as follows:

"The board of the health authority will establish a performance-based component of compensation for the Chief Executive Officer and may extend its provisions to other senior executives at its discretion."

In our view, this incentive is limited in its clarity and effectiveness. The lack of effective incentives and consequences is a major weakness of the current performance agreements, and needs to be addressed when the next set is developed. To be effective, we think that incentives should focus on the few, significant measurable results expected. Moreover, the person or group receiving the incentive should be able to significantly influence the expected results. Incentives are ineffective if the connection between effort and reward is too tenuous to be valid.

Everyone we interviewed spoke about their main motivators being pride and professionalism, traditional values of the public service culture. These were seen as stronger motivators than financial penalties or rewards. Also, many spoke of the most desirable incentive they wanted: the right to make decisions and manage independently. They saw this as being a reward they could win through demonstrated performance.

The incentive in the existing agreements focuses on an individual, even though these performance agreements are between organizations. We therefore suggest that organizational incentives and consequences be considered and built into the new agreements. A variety of different mechanisms are being used in other jurisdictions or are mentioned in the literature. They include:

- publicly reporting on whether expectations set out have been met;
- providing greater responsibility and/or autonomy;

- organizational gain sharing (this is currently in place in British Columbia); and
- making awards (financial or other) to recognize achievement.

In an earlier section, we addressed the need for continuous learning and improvement. However, as a matter of last resort, the agreements should provide for situations where poor performance leads to significant consequences. Both parties should be aware of the possibility of such consequences, and as far as is possible, the circumstances in which they would be applied. Consequences can move along a continuum, from minor to major. In effect, they are the other side of incentives:

- Minor consequences usually involve the withdrawal of specific decision-making abilities. If a health authority has, in the eyes of the ministry, erred in a significant area of management, then the ministry can require closer scrutiny, pre-clearance of decisions, and perhaps a site visit from a ministry representative.
- Medium-level consequences involve a general withdrawal of autonomy or freedom to make decisions, and more frequent visits by ministry staff, inspectors, auditors and so on.
- Major consequences effectively place the health authority "in receivership." The Minister can dismiss the board and/or senior management and send in an administrator.

While we support the use of financial and non-financial incentives and consequences in performance agreements, we urge a cautious and thoughtful approach to their application. In Appendix C, "The Various Uses and Misuses of Indicators: Wait Times for Medical Procedures," we offer an illustration of the complexity and potential for inappropriate use of performance measures. The situation in question is the measurement of wait times for medical procedures. We note that in a recent incident in the UK, several local health authorities were found to have made inappropriate adjustments to their wait lists in order to meet ministry-set targets. While we are not implying that this would happen in British Columbia, international experience suggests that a crude "pass/fail" approach to rewards and sanctions should be avoided.

Recommendation

We recommend that the performance agreements include an adequate package of incentives, and that they outline a graduated set of consequences for poor performance so that parties to the agreement have clarity about when and how they would be applied.

Response from the Ministry of Health Services and Ministry of Health Planning

General Comments

The Ministry of Health Services is committed to strengthening accountability throughout the public health system and ensuring full public confidence in how the system is governed and managed. As such, the ministry appreciates the work of the Office of the Auditor General in reviewing the new performance agreements between the ministry and the health authorities. In particular, the ministry acknowledges the collegial and consultative approach of the OAG staff involved in preparing this report.

The health authorities provide a very broad range of health services to the public, accounting for nearly 25 cents of every dollar the government spends. Given the scope of their mandate, the high public interest in ensuring accountability for health care decision-making and the complexity of the health system, the performance agreements are a critical component among a range of measures needed to ensure accountability. While some of the recommendations in the report will be challenging to implement within this context, they will be a valuable reference point as the work progresses.

The report itself is timely, providing an objective review of the strengths and weaknesses of the first version of the agreements. This review will be used by the ministry in working with the health authorities to develop the 2004/05 performance agreements. It should be noted the new framework for the Health Service Plans will provide guidance for changes to the performance agreements. The ministry will be developing a joint process with the health authorities for the further development and maintenance of the performance measures.

The ministry takes its stewardship role in the delivery of health care services very seriously and will continue to work closely with the health authorities to ensure our performance measures, and the principles by which they are developed, are clear, transparent and effective.

A. Governance

A-1 'the purpose of the performance agreements be clearly defined and that the agreements then be designed around that purpose. ...the organisational performance agreement model is the closest fit to what....(is) the primary purpose of these documents' (p 17).

The ministry agrees that the main purpose of the agreements needs to be defined more clearly, better understood, and that the structure of the agreement should reflect this. This recommendation is closely linked to the first of the accountability recommendations, concerning the need for clear objectives for the system and clarification of the role of the agreement among all the means through which the ministry provides direction and exerts control on the authorities.

A-2 'the performance agreements be better structured to clarify the roles and responsibilities for leadership and service delivery and to focus on higher-level performance expectations.' (p18)

The need to clarify the relative roles and responsibilities of the ministry and the health authorities is agreed. The ministry is focussing its work on high-level strategic planning (e.g. the Health Service Plans) in order to provide the health authorities with a clear structure and directions within which they will provide services.

In part, this recommendation has been acted upon in the 2003/04 agreements where the respective roles and responsibilities of the ministries and health authorities have been outlined in the Reciprocal Obligations section.

A-3 'the ministry and health authorities work to reduce ambiguity over decision-making authority by adopting a decision-making framework that articulates who is accountable for which decisions and how exceptional cases will be handled. We recognize that this will be a complex undertaking due to the inherent difficulties in governing within a publicly funded health care system.' (p21)

The ministry agrees with the intent of this recommendation. The new Health Service Plan articulates the relative roles of the authorities and the ministry, further defining accountability for decision-making.

A-4 'the performance agreements be signed by the Minister and the Chair on behalf of the health authority board, as they are directly accountable for responsibilities being delegated within the performance agreements. Consideration should also be given to defining the roles of the Deputy Minister and CEOs in separate management agreements.' (p23)

The ministry agrees the Minister and Chairs should sign the agreements. However, the significant scope of health authority operations and their impact on the public and policies of government requires that the Deputy Minister and Chief Executive Officers continue to be co-signers of the agreements in a manner that articulates their operational responsibilities and relationship.

A-5 'As the performance agreements are further developed and implemented, we recommend that they be consistent with this approach and be based on the values of mutual respect and cooperation.' (p24)

The ministry has used the new structure of 6 health authorities, and the development of the Leadership Council to make significant progress in developing a partnership based on mutual respect and cooperation. The ministry will continue to build on this important relationship.

A-6 'health authority boards evolve their board performance evaluation process from self-assessment to include periodic assessment by an independent third party within a reasonable time period.' (p26)

The ministry agrees that this would be a further constructive step in evaluating the effectiveness of the new accountability structure.

B. Accountability

B-7 'that the 'givens' be distilled and clarified into a set of clear objectives for the regional health care system that are prioritized and balanced. In our view, this is the single biggest improvement that can be made to enable the agreements to become **the** key accountability documents for health authorities.' (p31)

The ministry agrees that greater clarity is required if the 'givens' are to serve as the key objectives of the regionalized health system. Integrating the Health Service Plans of the ministries and the agreements will help to establish a set of clear and consistent objectives.

*The recommendation that the agreements become **the** key accountability documents for health authorities is accepted, particularly as this relates to the identification of areas where*

change is expected. It must be recognized, however, that the authorities have many duties under law, for which they are accountable, and that in the health sector there are frequent unanticipated issues that may arise which may require action. Thus, while the agreement is a very important part of the identified accountabilities of the authorities, it will not be the sole focus of the ministry's performance management responsibilities.

B-8 'continue to strengthen the linkages between the agreements and current planning processes through better coordination; and include the agreements in the ministry's comprehensive planning framework, so that they are part of the long-term plans for the health care system' (p32)

As noted above, the ministry has already worked to link the Health Service Plans of the ministries and the agreements. This linkage will be strengthened in future development of the performance agreements.

B-9 'The ministry and health authorities are making several positive changes to link management systems and capacity to the performance agreements. We recommend that continued improvements, especially to support organisational capacity, are needed over time to ensure the system operates in a cohesive, consistent and holistic way.' (p34)

The ministry agrees with this recommendation.

B-10
- 'a more collaborative approach be used in drafting the performance agreements that allows for greater participation from health authorities;'
- the evolution of the agreements be more considered and strategic, rather than rushed through a once-a-year process; and
- the agreements be made part of the ministry's and health authorities' ongoing management and decision-making processes, with performance-related discussions occurring on a regular basis and if necessary, mutually agreed upon changes made due to significant, unforeseen circumstances.' (p35)

The ministry agrees with these recommendations. It was never the intention to have a 'rushed through once-a-year process.' The timetable for the first agreements meant that little time was available for consultation. In updating the second year of the agreements there has been more consultation with the health authorities. There is agreement that the focus of attention will be on collaboratively developing the 2004-05 agreements through the establishment of a joint working committee with representation from each of the health authorities.

The measures in the present agreements are already used by the ministry as the basis of monitoring the performance of the authorities. The 2003/04 – 2005/06 version of the agreements contains a new obligation on the part of the ministry to consult with the authorities in the event of major changes in circumstances.

C. Performance Measurement and Reporting

C-11 'the ministry and the health authorities work to bring focus to the performance agreements by emphasising the measurement of results, and by working to select only those measures essential for decision-making.' (p38)

The ministry agrees with the advantages of a focussed agreement in providing clear direction and with the desirability of having measurable results. While an emphasis will be placed on the measurement of performance in the areas selected by government for major change, attention will also be given to the routine operation of the health authority in its provision of all major services.

C-12 'that the performance agreements include long-term measures of success, as well as measures relating to short-term improvements.' (p39)

The ministry understands the intent of this recommendation, and will incorporate this direction in the agreements where possible.

Given that forces outside the authority's control may often affect longer-term outcomes, there may be occasional circumstances in which this recommendation cannot be applied. As an example, the health status of the population is significantly affected by the determinants of health – factors such as socio-economic status, housing, education and other social forces. Health authorities can work to effect change in these areas, and to cope with the health

consequences, but cannot reasonably be held solely accountable for the outcomes.

C13 'the ministry and the health authorities adopt the eight guiding principles established by the Steering Committee on Reporting Principles and Assurance (adapting them to the province's health care system) to guide the performance measure selection process.' (p42)

The ministry agrees that a set of principles should guide the selection of performance measures and will discuss with its partner health authorities the applicability of the recommended set presented in the report. This will be part of the mandate of the working group established with the health authorities to develop the new agreement for 2004/05.

C-14 'the ministry and the health authorities work together to create a balanced framework of key performance measures based on strategic objectives and priorities and linked to decision-making needs..... consider using a framework including the following domains of performance to support evidence-based decision-making:

- Service levels and access
- Service quality and appropriateness/client outcomes
- Client satisfaction
- Financial results
- Efficiency/productivity
- Sustainability/capacity' (p46)

The ministry agrees that a framework of domains that covers the broad areas of health authority service is necessary. The 6 domains listed in the report appear to be comprehensive and will be reviewed with the authorities to determine the framework that will best meet the needs and capabilities of the health system

C-15 The ministry and the health authorities should agree on a process to select measures in a considered, participative manner.' (p46)

The ministry agrees with this recommendation. It is part of the mandate of the working group on the new agreement to recommend a joint process for the development of the performance measures.

C-16 'the ministry and the health authorities consider using logic models as part of the process of selecting measures of outcomes for the BC health care system.' (p48)

Where appropriate, the ministry and the health authorities will make use of logic models in developing key outcome measures. The logic model approach was used in the development of the 2003/04 – 05/06 ministry Health Service Plans.

C-17 'the ministry and the health authorities work together to establish sound data on current performance, set a philosophy of continuous improvement, ensure all targets are as measurable and clear as possible, and tie incentives to the targets. Ultimately, the ministry and the health authorities should be working to achieve a 'gold standard' over a reasonable period. We recognize that this will be a difficult task, and that improvements will only come as experience is gained' (p53)

The ministry strongly agrees with the need to have sound data with which to monitor performance and on which to base decisions. Work is underway to clearly identify what data are required of the authorities by the ministry and why. The ministry will work to ensure that changes are consistent with its accountability requirement to monitor health authority performance and to evaluate programs and services.

C-18 'that the performance agreements include reporting provisions that are based on a careful analysis of decision-making needs, and using emerging technologies for performance reporting' (p54)

The ministry agrees with this recommendation and is developing both a detailed listing of reporting requirements (including the use made of the data) and plans for streamlining the collection of the data from authority operational systems. These plans will be accelerated as resources become available to correct the lack of a modern IT infrastructure in the health authorities.

C-19 'that the ministry and the health authorities establish a joint program of independent audits and evaluations for the health sector in British Columbia.' (p55)

Joint efforts between the authorities and the ministry to improve data quality are ongoing. A number of the authorities

have established internal audit functions and the regular sharing of comparative information between the ministries and the authorities is a routine mechanism to identify issues of quality and consistency. The ministry has invested $8 million in the Michael Smith Research Foundation specifically to independently evaluate the results of changes in the province's health service system.

C-20 'the performance agreements include an adequate package of incentives, and that they outline a graduated set of consequences for poor performance so that parties to the agreement have clarity about when and how they would be applied.' (p58)

The ministry understands the desire of the auditors to have clear incentives and consequences for performance. The ministry believes that the culture of trust and mutual respect referred to elsewhere in the report fosters excellence and the advance of the system as a whole. The balance between a constructive relationship with the authorities and the reality that the ministry is accountable for their performance overall is not one that lends itself to the application of a rigid set of incentives and penalties.

Evidence from other jurisdictions shows the desire of people to do a good job, and be known for this by their peers, is a strong incentive. Public transparency with regard to results is a powerful motivation for quality improvement. The experience in other jurisdictions and in the literature have shown that the introduction of penalties can serve to encourage undesirable behaviour such as false reporting and a defensive approach to information sharing rather than one that is open to and desires change.

The ministry will be regularly sharing reports with the health authorities on their performance relative to each other and to the performance measures in the agreement. This will encourage good performance and identify areas where performance can be improved. The publication of reports will enable the performance of the authorities to be followed by the public and is another means of encouraging continuous improvement.

Appendices

Appendix A: Example of a Performance Agreement

PERFORMANCE AGREEMENT

between

THE MINISTRY OF HEALTH SERVICES

and

XXX HEALTH AUTHORITY

APRIL 1, 2002 TO MARCH 31, 2003

Appendix A: Example of a Performance Agreement

PERFORMANCE AGREEMENT – 2002/03
XXX HEALTH AUTHORITY

This is an agreement between the XXX Health Authority and the Ministry of Health Services, setting out our mutual understanding of the respective expectations and performance deliverables for the three fiscal years, 2002/03, 2003/04, and 2004/05. It will be updated and renewed annually for a new three-year period.

Given that:

- The government is committed to providing high quality patient-centred care, improved health and wellness for British Columbians and a sustainable, affordable public health system;
- The government is committed to substantial restructuring of the health care system, while maintaining the priority of patient needs;
- The government expects the health authority to continue to meet the requirements of the various legislation, regulation and policy, remaining in force at April 1, 2002, subject to amendments made from time to time by the Government of British Columbia;
- The government has established directions in A New Era for British Columbia and the Ministry of Health Services Service Plan;
- The government has provided guidance to the health authority through the letter of expectation to the Chair of the Board from the Minister of Health Services, dated December 12, 2001;
- The government will monitor programs, services, and performance indicators to ensure compliance with the above direction and guidance;
- The health authority will continue to provide a broad range of health care and health protection services such as those provided by its predecessor health authorities;
- The health authority will continue to provide comprehensive, accurate, and timely reporting (financial, statistical, program-related, and person-based), as required by the Ministries of Health.

The parties hereby specifically agree that:

The Ministry of Health Services, in conjunction with the Ministry of Health Planning, will:

1. Provide in writing, to the XXX Health Authority, details of operating and notional capital funding allocated for each fiscal year, no later than February 22, prior to the start of the fiscal year, and a three-year estimate of future funding levels.
2. Provide total Regional Health Sector operating funding for the 2002/03 fiscal year of xxx million (as per the April 25, 2002 Ministry of Health funding update letter), by electronic transfer to the health authority, in 26 bi-weekly amounts, together with a notional allocation of $xxx million for Capital funding, as shown in the 2002/03 allocation to health authorities, enclosed with this agreement. Funding allocations from other sources within the Ministries of Health will be communicated separately.
3. Provide to the health authority, within one month from receipt, an assessment of the health service redesign plan and budget management plan as submitted by the health authority. This assessment may include additional requirements of the health authority and will constitute an addition to this agreement as Schedule B.

Appendix A: Example of a Performance Agreement

PERFORMANCE AGREEMENT – 2002/03
XXX HEALTH AUTHORITY

The XXX Health Authority will:

1. Develop and deliver to the Ministry of Health Services by March 22, 2002, a three-year health service redesign plan and a corresponding budget management plan. The health service redesign plan must conform to existing health care policy and standards. The budget management plan must be balanced over 2002/03 and 2003/04 in total, and balanced for 2004/05.

   Manage and deliver programs and services for the fiscal year ended March 31, 2003, such that the operating results are equivalent to or better than those projected in the budget submission. Additionally, the unrestricted net assets (including internally restricted funds) at the end of fiscal 2004/05 must be equal to or better than the unrestricted net assets (including internally restricted funds) as at March 31, 2001.

2. Take action to achieve the objectives set out in the Priority System Performance Improvements shown in Schedule A, collaborating where appropriate with the Ministries of Health and other health authorities.

3. Agree to perform the additional actions outlined by the Ministries of Health in the response to the health authority's health service redesign plan and budget management plan shown in Schedule B.

   The Board of the health authority will establish a performance based component of compensation for the Chief Executive Officer and may extend its provisions to other senior executives at its discretion.

   In the event of significant changes in government policy which will seriously reduce the ability of the health authority to achieve the targets set out in this agreement, the parties to this agreement agree to renegotiate its terms to their mutual satisfaction.

Agreed to, on behalf of the XXX Health Authority, by:

Original Signed by: Chair of the Board

Original Signed by: Chief Executive Officer

Agreed to, on behalf of the Ministry of Health Services, by:

Original Signed by: Honourable Colin Hansen Minister of Health Services
Original Signed by: Penny Ballem Deputy Minister

Appendix A: Example of a Performance Agreement

PERFORMANCE AGREEMENT – 2002/03
XXX HEALTH AUTHORITY

SCHEDULE A
PRIORITY SYSTEM PERFORMANCE IMPROVEMENTS

1. Emergency Health Services:

Expected Performance

Within the process directed and supported by the Provincial Health Services Authority, collaborate with the Ministries of Health and other health authorities in developing guidelines to better manage demands on the emergency health services in the acute hospital system.

The process will include a review of literature and research as well as practices and performance in other jurisdictions.

Subject to the early initiation of the process by the Provincial Health Authority and with the cooperation of the physicians in the Northern Health Authority, the product by year will be as follows:

a) 2002/2003 will be a set of guidelines for best practices in the management of emergency health care, including reporting requirements, measures, and assessments of service coordination. These guidelines will be adopted by the health authorities.

b) 2003/2004 will be implementation of the recommended practices, including recording, reporting, and measurements.

c) 2004/2005 will be improvement of the performance of the emergency health services in the health authority, as measured by these best practices, reporting requirements, measures, and assessments of service coordination.

Measures may include an implemented flu season response plan, regular sample surveys of the movement of selected marker conditions through the emergency system, and a reduction in wait times and periods on diversion in the emergency departments.

The work will include representation from the B.C. Ambulance Service.

2. Surgical and Procedural Services

Expected Performance

Within the process directed and supported by the Provincial Health Services Authority, collaborate with the Ministries of Health and other health authorities in developing measures of the performance of surgical and procedural services in the province's hospitals.

The process will include the establishment of measures of the performance of the system in response to emergency treatments and procedures and the development of principles for establishing priority for care for non-emergency conditions/cases.

Appendix A: Example of a Performance Agreement

Subject to the early initiation of the process by the Provincial Health Authority and with the cooperation of the physicians in the XXX Health Authority, the product by year will be as follows:

a) 2002/2003 will be:

   i. the development of measures of the response of the health care system to emergency surgical and procedural needs;

   ii. agreement on the principles to be used by health authorities in classifying cases as emergent or urgent/elective;

   iii. a plan to measure the appropriateness and outcomes of selected procedures (RESIO); and

   iv. adoption by the health authority of these principles and measurement procedures.

b) 2003/2004 will be the introduction of these principles and measurement procedures.

c) 2004/2005 will be demonstrated improvement of the performance of the surgical services.

3. Mental Health Services

Subject to the provision by the Ministry of Health Services of the capital required for construction of Riverview replacement facilities and the annual funding for the operation of these facilities being transferred with the patient coming from Riverview; and the validation of mental health patient information data, expected performance will be as follows:

a) Increased use of needs-based and evidence-based best practices to achieve:

   i. Increase in early intervention capacity as evidenced by the decrease in average patient age at first contact with a physician or health service provider for serious mental illness;

   ii. Decrease, by 4 percent over three years, in the alternate level of care days spent by mental health and alcohol and drug clients in hospitals once the primary need for inpatient care has completed, specifically:

   Target 02/03 zero %

   Target 03/04 2 %

   Target 04/05 2 %

   iii. Improved continuity of care measured by the proportion of persons hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.

   Target 02/03 3 %

   Target 03/04 3 %

   Target 04/05 3 %

b) Development of Riverview replacement units in selected locations—to be achieved over the 3 year period, specifically:

Target 02/03 x units

Target 03/04 x units

Target 04/05 x units

4. Home and Community Care

Expected Performance

a) Full implementation of the new assessment tool for home care (MDS-HC) over the next three years.

b) Full implementation of the new assessment tool for residential care (MDS V2.0) over the next five years.

c) Increase the proportion of home and community care clients with high care needs (requiring care at the IC2 level or higher) living in their own home, or in non-institutional facilities.

This is indicated by the number of high care needs clients at home or noninstitutional facilities as a percentage of high care needs clients in total.

Target 02/03 2 % increase (e.g. from 45% to 47%)

Target 03/04 5 % increase (e.g. from 47% to 52%)

Target 04/05 5 % increase (e.g. from 52% to 57%)

Targets will need to be re-evaluated with the emergence of high needs young adults entering the healthcare system.

5. Public/Population Health

Expected Performance

a) Collaborate with all other health authorities and the Ministries of Health in the development of core prevention and protection programs, and in the review of literature and research of best practices and performance in other jurisdictions.

Participate in consultations which will begin in 2002/03 and will result in:

i. In 2002/03, the development of a list of prioritized core programs for protection and prevention;

ii. In 2003/04, the development of core program delivery expectations and performance measures; and

iii. In 2004/05, the incorporation of appropriate core programs into a new Public Health Act.

b) Implement the recommended core programs, including recording, reporting, and measurements in 2004/05.

c) In 2004/05 improve the performance of the core prevention and protection programs as measured by the indicators developed as above.

6. Support and Administrative Services

Expected Performance

a) Reduce the annual expenditures for Support and Administrative Services

(excluding Information Systems), by the 2004/05 fiscal year, by at least 7 percent of these expenditures incurred for the fiscal year 2001/02.

Note: Annual or multi-year targets for individual authorities, for each priority program area, will be determined in negotiation with the Performance Management and Improvement Division.

Appendix A: Example of a Performance Agreement

PERFORMANCE AGREEMENT – 2002/03
XXX HEALTH AUTHORITY

SCHEDULE B
OUTSTANDING ISSUES

The Ministry of Health Services has approved the xxx Health Authority's health services redesign and budget management plan with the understanding the following issues require ongoing discussion and subsequent action:

- Confirmation the proposed transition in acute services, in relation to other health sectors, will be implemented in a planned, integrated, and timely manner.
- Submission of a comprehensive transition plan, including the timetable and implementation strategies, for achieving the New Era commitments for home and community care.
- A clear articulation of the changes planned for mental health services, confirmation these changes complement the implementation of the British Columbia Mental Health Plan, and are integrated across the health sector.
- Confirmation that utilization management plans exist for the region.
- Delineation of the steps to be taken to strengthen primary care services in the region.
- Confirmation that maternity care delivery is consistent with the British Columbia Reproductive Care Program *Report on the Findings of a Consensus Conference on Obstetrical Services in Rural or Remote Communities* (February 2000).
- Confirmation of progress in the implementation of the health authority's medical academic program.
- Submission by the health authority of an aboriginal health plan by September 3, 2002, and linkage of this plan to other health services.
- Provision of a revised budget management plan, by June 30, 2002, which reflects unrestricted net assets (including internally restricted funds) at the end of fiscal 2004/05 that are equal to or better than unrestricted net assets (including internally restricted funds) as at March 31, 2001.
- Provision of a three year calendarized implementation schedule which links initiatives in the health service redesign plan to the revised budget management plan by June 30, 2002.
- Provision of a combined program and financial risk mitigation and contingency plan by June 30, 2002.
- Submission of any outstanding capital asset funding details, including:
  - the funding source for projects, which maybe proceeding (i.e. health authority restructure funding, CIP/equipment funding, health authority debt service/amortization). These projects are cited in Attachments D and E of the February 4, 2002, letter from the Ministry of Health Services.
  - project lists and individual project details as noted in Appendix 1 of the Health Service Redesign and Budget Management Plans instructions.

Appendix B: Performance Measurement Developments in Other Jurisdictions' Health Care Sectors

Some countries and jurisdictions have been early leaders in the quest for performance measurement and accountability in their health sectors. We commissioned a review of developments to see what choices these other jurisdictions have made, what lessons they have learned, and what they plan to do next.

Overseas, the review looked at developments in the United Kingdom, New Zealand, and New South Wales. The trends are fairly consistent across these jurisdictions:

- All have developed performance frameworks based on comprehensive strategic plans for the system as a whole, and supported by regional plans.
- There is a shift from using generic indicators to measuring performance against stated expectations These expectations are negotiated in the context of the strategic plans and communicated in service agreements.
- Use of audits and evaluations is increasing to complement information provided by indicators.
- They show strong commitment to improving the measurement and reporting process: they have continuous processes and dedicated resources.
- Most have agreements that include pre-established incentives and consequences, with a shift to a non-punitive culture. The mindset that accompanied the early agreements was that of a business contract- somewhat adversarial, arm's length, focused on dollars, service volumes, sanctions and rewards. The new mindset is that of mutual co-operation, supported by a common use of the information to learn and improve.
- The emerging role of central ministries is that of stewards of the system, setting direction rather than delivering services.
- There is an increasing focus on outcomes, and less on compliance. Policy directives are being replaced by outcome targets and measures As well, planning, especially with regard to risk, is now seen as being as important as measurement
- National or state-level measures of population health are not seen as relevant to assessing service performance.
- The focus of performance measurement is shifting from inputs and service volumes to measures of quality and immediate outcomes.

Appendix C: The Various Uses and Misuses of Indicators: Wait Times for Medical Procedures

Choosing indicators of performance is a critically important activity in the health sector. The chosen indicators influence priorities and behaviours. They are used for different purposes, some appropriate, others less so. The numbers are often reported in the media as valid and reliable representations of reality. However, indicators can be ambiguous in their meaning. It is important to acknowledge both their potential and their limitations. They are tools and, like all tools, can be well or improperly used.

Wait times for procedures is a good example of an indicator that could contribute substantially to the public good or be misused. The indicator was one of the federal-provincial accountability elements built into the September 2000 First Ministers' Memorandum. Several provinces have committed to reporting on wait times. Wait times are widely reported by the media, but without examination of their methodological rigour or validity. There is, therefore, a significant potential for misuse and misinterpretation.

At first glance, measuring wait times for procedures seems straightforward, but it isn't. To be truly meaningful and accurate, comparison of hospital, regional, or provincial wait times would have to be based on the following preconditions:

- All parties involved would have to agree on when the clock starts for waiting. Is it when the person makes an appointment with the family doctor? Is it when the family doctor makes a referral to a specialist? When the specialist decides a procedure is warranted? When the procedure is actually booked?
- All parties involved would have to agree on when to place people on a waiting list. Some physicians may decide their patients need a procedure at a certain point of development of the problem, while others might delay. In these circumstances, reported wait time differences might be misleading. Waiting even a short time may create major hardships and suffering for very needy cases, while waiting a comparatively long time may be the preferred option for those whose needs are minor.

Appendix C: The Various Uses and Misuses of Indicators: Wait Times for Medical Procedures

- All parties involved would have to agree on whether the calculations should be done prospectively or retrospectively. For example, wait times could be calculated by following a cohort of patients enrolled during, say, a three-month period through to when they actually receive the service. Another method could be to review, say, a month's worth of procedures actually performed and work backwards to calculate how long each person has waited. In the first instance, there will be patients who are not served during the time period under scrutiny, including some who never intend to undergo treatment. In the second case, the calculations will miss some patients waiting very long periods of time who have not, for some reason, actually received service.
- The wait lists would have to be audited for completeness and accuracy. International experience has revealed that up to 50% of cases on wait lists shouldn't actually be there. There are several reasons for this: the person has left, has been double-counted, has already had the procedure, doesn't intend to have the procedure, and so on. A 30% "false positive" rate is common.
- Wait list managers would have to know and record how many patients postponed their own procedures. Again, this happens frequently. In one study, about 20% of Saskatchewan cataract surgery patients chose to delay their procedures. If people are waiting two years because the system is under-resourced or disorganized, that is a problem. If people wait two years because they want to, the long wait is no indication that anything is amiss.
- Wait lists are usually categorized by whether patients are emergent, urgent or elective. There are major differences in how especially urgent and elective patients are defined in different jurisdictions. We cannot know the true state of people who are waiting unless there is a common definition of the levels of severity, applied consistently.

While none of this standardization exists, wait times get reported nonetheless. It is true that data tend to get better once initial results are reported. However, it would be risky to form a judgement about what the numbers mean, even with the best data available, without rigorous analysis.

Indicators need context; they should be part of a package. It is inappropriate to report on wait times without also reporting on appropriateness. If people are waiting for procedures they may not genuinely need, the problem may be minimal. If the people who wait a long time are marginal cases, it could be in their best interests to have their procedure done later than sooner. If wait times are generally short, but some people in serious need have to wait several months, then the overall appearance of good performance may mask considerable injustice and adverse effects on health status for some.

Finally, a full understanding of wait times is impossible without comparing overall rates at which procedures are done. If wait times are long but intervention rates are very high, it could be that waiting is used as a reasonable rationing tool (although it would be better to standardize the indications for procedures and apply them consistently and fairly). If wait times are low and rates of intervention are low, it could be that the system simply doesn't serve certain kinds of patients very well, and leaves a good deal of unaddressed need in the community.

The following table illustrates these issues:

Appendix C: The Various Uses and Misuses of Indicators: Wait Times for Medical Procedures

Indicator	Common Interpretation	Could Also Mean	What Data Are Needed	What We Have
Mean wait times by procedure	The mean is the average time people wait	The mean masks huge variations	% of patients waiting for selected intervals	Means and distributions are available
Median wait times by procedure	The typical time people wait, hence a better descriptor than the mean	The system does a good job for 50% of patients, but waits beyond the median are erratic and long	As above	Medians (most commonly reported) and distribution of wait times
Number of urgent and elective patients waiting by procedure	The number of serious cases languishing on wait lists is a proxy for unmet need/insufficient capacity	There are major variations in how patients are classified; less serious cases may be handled ahead of more serious cases	Standardized definitions of elective and urgent; common patient need scales: Reports on correl-ation between need and wait times	Classification systems, but no standardization or monitoring to examine whether practices are consistent within and between jurisdictions
"Long wait" reports by procedure	Substantial numbers of people waiting a long time (e.g., six months or more) indicate lack of capacity	Patients fall through the cracks and wait longer than needed because of inattention; some physicians' patients have better access to service than others' patients; some patients post-pone their own procedures; "anticipatory booking" by physicians places people on lists well before they are expected to need the procedure; wait lists are not kept up to date and patients are not deleted once the procedure is done	Standardized criteria for determining need and priority; measures of system capacity to meet needs if organized optimally to minimize waits and distribute access fairly	Raw numbers with little understanding of why the long waits occur

Source: Steven Lewis, Adjunct Professor of Health Policy, University of Calgary (adapted)

Indicators can be innocently or deliberately misused. Some may lead to premature conclusions, or result in inappropriate solutions to poorly understood or non-existent problems.

Appendix C: The Various Uses and Misuses of Indicators: Wait Times for Medical Procedures

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Median wait times by procedure	The typical time people wait, hence a better descriptor than the mean	The system does a good job for 50% of patients, but waits beyond the median are erratic and long	As above	Medians (most commonly reported) and distribution of wait times
Number of urgent and elective patients waiting by procedure	The number of serious cases languishing on wait lists is a proxy for unmet need/insufficient capacity	There are major variations in how patients are classified; less serious cases may be handled ahead of more serious cases	Standardized definitions of elective and urgent; common patient need scales: Reports on correl-ation between need and wait times	Classification systems, but no standardization or monitoring to examine whether practices are consistent within and between jurisdictions
"Long wait" reports by procedure	Substantial numbers of people waiting a long time (e.g., six months or more) indicate lack of capacity	Patients fall through the cracks and wait longer than needed because of inattention; some physicians' patients have better access to service than others' patients; some patients post-pone their own procedures; "anticipatory booking" by physicians places people on lists well before they are expected to need the procedure; wait lists are not kept up to date and patients are not deleted once the procedure is done	Standardized criteria for determining need and priority; measures of system capacity to meet needs if organized optimally to minimize waits and distribute access fairly	Raw numbers with little understanding of why the long waits occur

Source: Steven Lewis, Adjunct Professor of Health Policy, University of Calgary (adapted)

Indicators can be innocently or deliberately misused. Some may lead to premature conclusions, or result in inappropriate solutions to poorly understood or non-existent problems.

Appendix D: Summary of Recommendations

Performance agreements have significant potential for being the key documents in which expectations regarding performance are well defined, and which guide governance in British Columbia's health sector. These recommendations reflect the findings in our review, and should help provide a basis for action to realize that potential.

Governance

- **We recommend that the purpose of the performance agreements be clearly defined and that the agreements then be designed around that purpose. In our view, the organizational performance agreement model is the closest fit to what most of the interviewees felt was the primary purpose for these documents. This model also seems to capture the intended level of accountability best—that being the organization.**
- **We recommend that the performance agreements be better structured to clarify the roles and responsibilities for stewardship and service delivery and to focus on higher-level performance expectations.**
- **We recommend that the ministry and health authorities work to reduce ambiguity over decision-making authority by adopting a decision-making framework that articulates who is accountable for which decisions and how exceptional cases will be handled. We recognize that this will be a complex undertaking due to the inherent difficulties in governing within a publicly funded health care system.**
- **We recommend that the performance agreements be signed by the Minister and the Chair of the health authority, on behalf of the board, as they are directly accountable for responsibilities being delegated within the performance agreements. Consideration should also be given to defining the roles of the Deputy Minister and CEOs in separate management agreements.**

- **We understand that both the ministry and the health authorities want to move towards a greater partnership relationship. As the performance agreements are further developed and implemented, we recommend that they be consistent with this approach and be based on the values of mutual respect and cooperation.**
- **We recommend that health authority boards evolve their board performance evaluation process from self-assessment to include periodic assessment by an independent third party within a reasonable time period.**

Accountability

- **We recommend that the "givens" be distilled and clarified into a set of clear objectives for the regional health care system that are prioritized and balanced. In our view, this is the single biggest improvement that can be made to enable the agreements to become the key accountability documents for health authorities.**
- **We recommend that the ministry and health authorities:**
  - **continue to strengthen the linkages between the agreements and current planning processes through better coordination; and**
  - **include the agreements in the ministry's comprehensive planning framework, so that they are part of the long-term plans for the health care system.**
- **The ministry and health authorities are making several positive changes to link management systems and capacity to the performance agreements. We recommend that continued improvements, especially to support organizational capacity, are needed over time to ensure the system operates in a cohesive, consistent and holistic way.**
- **We believe that:**
  - **a more collaborative approach be used in drafting the performance agreements that allows for greater participation from health authorities;**

- **the evolution of the agreements be more considered and strategic, rather than rushed through a once-a-year process; and**
- **the agreements be made part of the ministry's and health authorities' ongoing management and decision-making processes, with performance-related discussions occurring on a regular basis, and if necessary, mutually agreed upon changes made due to significant, unforeseen circumstances.**

Performance Measurement and Reporting

- **We recommend that the ministry and the health authorities work to bring focus to the performance agreements by emphasizing the measurement of results, and by working to select only those measures essential for decision-making.**
- **We recommend that the performance agreements include long-term measures of success, as well as measures related to short-term improvements.**
- **We recommend that the ministry and the health authorities adopt the eight guiding principles established by the Steering Committee on Reporting Principles and Assurance (adapting them to the province's health care system) to guide the performance measure selection process.**
- **We recommend that the ministry and the health authorities work together to create a balanced framework of key performance measures based on strategic objectives and priorities and linked to decision-making needs. We suggest that the British Columbia health care system consider using a framework including the following domains of performance to support evidence-based decision making:**
  - **Service levels and access**
  - **Service quality and appropriateness/client outcomes**
  - **Client satisfaction**
  - **Financial results**
  - **Efficiency/productivity**
  - **Sustainability/capacity.**

Appendix D: Summary of Recommendations

- **The ministry and the health authorities should agree on a process to select measures in a considered, participative manner.**
- **We recommend that the ministry and the health authorities consider using logic models as part of the process of selecting measures of outcomes for the British Columbia health care system.**
- **We recommend that the ministry and the health authorities work together to establish sound data on current performance, set a philosophy of continuous improvement, ensure all targets are as measurable and clear as possible, and tie incentives to the targets. Ultimately, the ministry and the health authorities should be working to achieve a "gold standard" over a reasonable period. We recognize that this will be a difficult task, and that improvements will only come as experience is gained.**
- **We recommend that the performance agreements include reporting provisions that are based on a careful analysis of decision-making needs and use emerging technologies for performance reporting.**
- **We recommend that the ministry and the health authorities establish a joint program of independent audits and evaluations for the health sector in British Columbia.**
- **We recommend that the performance agreements include an adequate package of incentives, and that they outline a graduated set of consequences for poor performance so that parties to the agreement have clarity about when and how they would be applied.**

Appendix E: Office of the Auditor General: Risk Auditing Objectives and Methodology

The Office has four lines of business:

- Attesting to the reliability of government financial statements;
- Assessing the quality of government service plan and reports;
- Assessing the management of risk within government programs and services; and
- Providing strong support to the standing committees of the Legislative Assembly.

Each of these lines of business have certain objectives that are expected to be achieved, and each employs a particular methodology to reach those objectives. The following is a brief outline of the objectives and methodology applied by the Office for assessing the management of risk within government programs and services, that is, risk auditing.

Risk Auditing

What are Risk Audits?

Risk audits (also known as performance or value-for-money audits) examine whether money is being spent wisely by government—whether value is received for the money spent. Specifically, they look at the organizational and program elements of government performance, whether government is achieving something that needs doing at a reasonable cost, and consider whether government managers are:

- making the best use of public funds; and
- adequately accounting for the prudent and effective management of the resources entrusted to them.

The aim of these audits is to provide the Legislature with independent assessments about whether government programs are implemented and administered economically, efficiently and effectively, and whether Members of the Legislative Assembly and the public are being provided with fair, reliable accountability information with respect to organizational and program performance.

Appendix E: Office of the Auditor General: Risk Auditing Objectives and Methodology

In completing these audits, we collect and analyze information about how resources are managed; that is, how they are acquired and how they are used. We also assess whether legislators and the public have been given an adequate explanation of what has been accomplished with the resources provided to government managers.

Focus of Our Work

A risk audit has been described as:

> *...the independent, objective assessment of the fairness of management's representations on organizational and program performance, or the assessment of management performance, against criteria, reported to a governing body or others with similar responsibilities.*

This definition recognizes that there are two forms of reporting used in risk auditing. The first—referred to as attestation reporting—is the provision of audit opinions as to the fairness of management's publicly reported accountability information on matters of economy, efficiency and effectiveness. This approach has been used to a very limited degree in British Columbia because the organizations we audit do not yet provide comprehensive accountability reports on their organizational and program performance.

We believe that government reporting along with independent audit is the best way of meeting accountability responsibilities. Consequently, we have been encouraging the use of this model in the British Columbia public sector, and will apply it where comprehensive accountability information on performance is made available by management.

As the risk audits conducted in British Columbia use the second form of reporting—direct reporting—the description that follows explains that model.

Our "direct reporting" risk audits are not designed to question whether government policies are appropriate and effective (that is achieve their intended outcomes). Rather, as directed by the Auditor General Act, these audits assess whether the programs implemented to achieve government policies are

being administered economically and efficiently. They also evaluate whether Members of the Legislative Assembly and the public are being provided with appropriate accountability information about government programs.

When undertaking risk audits, we look for information about results to determine whether government organizations and programs actually provide value for money. If they do not, or if we are unable to assess results directly, we then examine management's processes to determine what problems exist or whether the processes are capable of ensuring that value is received for money spent.

Selecting Audits

All of government, including Crown corporations and other government organizations, are included in the universe we consider when selecting audits. We also may undertake reviews of provincial participation in organizations outside of government if they carry on significant government programs and receive substantial provincial funding.

When selecting the audit subjects we will examine, we base our decision on the significance and interest of an area or topic to our primary clients, the Members of the Legislative Assembly and the public. We consider both the significance and risk in our evaluation. We aim to provide fair, independent assessments of the quality of government administration and to identify opportunities to improve the performance of government. Therefore, we do not focus exclusively on areas of high risk or known problems.

We select for audit either programs or functions administered by a specific ministry or government organization, or cross-government programs or functions that apply to many government entities. A large number of such programs and functions exist throughout government. We examine the larger and more significant of these on a cyclical basis.

Our view is that, in the absence of comprehensive accountability information being made available by government, risk audits using the direct reporting approach should be undertaken on a five- to six- year cycle so that Members of the Legislative Assembly and the public receive assessments of all significant government operations over a reasonable time period. We strive to achieve this schedule, but it is affected by the availability of time and resources.

Appendix E: Office of the Auditor General: Risk Auditing Objectives and Methodology

Planning and Conducting Audits

A risk audit comprises four phases—preliminary study, planning, conducting and reporting. The core values of the Office—independence, due care and public trust—are inherent in all aspects of the audit work.

Preliminary Study

Before an audit starts, we undertake a preliminary study to identify issues and gather sufficient information to decide whether an audit is warranted.

At this time, we also determine the audit team. The audit team must be made up of individuals who have the knowledge and competence necessary to carry out the particular audit. In most cases, we use our own professionals, who have training and experience in a variety of fields. As well, we often supplement the knowledge and competence of our staff by engaging one or more consultants to be part of the audit team.

In examining a particular aspect of an organization to audit, auditors can look either at results, to assess whether value for money is actually achieved, or at management's processes, to determine whether those processes should ensure that value is received for money spent. Neither approach alone can answer all the questions of legislators and the public, particularly if problems are found during the audit. We therefore try to combine both approaches wherever we can. However, because acceptable results-oriented information and criteria are often not available, our risk audits frequently concentrate on management's processes for achieving value for money.

If a preliminary study does not lead to an audit, the results of the study may still be reported to the Legislature.

Planning

In the planning phase, the key tasks are to develop audit criteria—"standards of performance"—and an audit plan outlining how the audit team will obtain the information necessary to assess the organization's performance against the criteria. In establishing the criteria, we do not expect theoretical perfection from public sector managers; rather, we reflect what we believe to be the reasonable expectations of legislators and the public.

Appendix E: Office of the Auditor General: Risk Auditing Objectives and Methodology

Conducting

The conducting phase of the audit involves gathering, analyzing and synthesizing information to assess the organization's performance against the audit criteria. We use a variety of techniques to obtain such information, including surveys, and questionnaires, interviews and document reviews.

Reporting Audits

We discuss the draft report with the organization's representatives and consider their comments before the report is formally issued to the Legislative Assembly. In writing the audit report, we ensure that recommendations are significant, practical and specific, but not so specific as to infringe on management's responsibility for managing. The final report is tabled in the Legislative Assembly and referred to the Public Accounts Committee, where it serves as a basis for the Committee's deliberations.

Reports on risk audits are published throughout the year as they are completed, and tabled in the Legislature at the earliest opportunity. We report our audit findings in two parts: an Auditor General's Comments section and a more detailed report. The overall conclusion constitutes the Auditor General's independent assessment of how well the organization has met performance expectations. The more detailed report provides background information and a description of what we found. When appropriate, we also make recommendations as to how the issues identified may be remedied.

It takes time to implement the recommendations that arise from risk audits. Consequently, when management first responds to an audit report, it is often only able to indicate its intention to resolve the matters raised, rather than to describe exactly what it plans to do.

Without further information, however, legislators and the public would not be aware of the nature, extent, and results of management's remedial actions. Therefore, we publish updates of management's responses to the risk audits. In addition, when it is useful to do so, we will conduct follow-up audits. The results of these are also reported to the Legislature.

Appendix F: Office of the Auditor General: 2003/04 Reports Issued to Date

Report 1

A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities

This report and others are available on our website at http://bcauditor.com

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